EXHIBIT 8
Dr. Stoltz Deposition Transcript

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

DAFINKA STOJCEVSKI, a/k/a STEPHANIE STOJCEVSKI, Individually, and as Personal Representative of the Estate of DAVID STOJCEVSKI, Deceased, Plaintiffs, -v- COUNTY OF MACOMB, SHERIFF ANTHONY M. WICKERSHAM, MICHELLE M. SANBORN, CORRECT CARE SOLUTIONS (CCS), LAWRENCE M. SHERMAN, M.D., DAVID ARFT, NATALIE PACITTO, MONICA CUENY, R.N., TIFFANY DELUCA, LPN, VICKI BERTRAM, LPN, SARA BREEN, LPN, MICAL BEY-SHELLEY, LPN, DIXIE DEBENE, LPN, THRESSA WILLIAMS, LPN, LINDA PARTON, LPN, AMBER BARBER, LPN, DEANN PAVEY, LPN, CHANTALLE BROCK, LPN, KELLY MANN, DANYELLE NELSON, MHP, OXLEY, COONEY, HARRISON, TALOS, PINGILLEY, AVERY, VANEENOO AND HELHOWSKI, Defendants.

Case No. 15-cv-11019

Hon. Linda V. Parker

Mag. David R. Grand

The telephonic deposition upon oral examination of RANDALL STOLTZ, M.D., a witness produced and sworn before me, Sherry D. Lenn, RPR, and Notary Public in and for the County of Warrick, State of Indiana, taken on behalf of the Plaintiffs at the offices of Stewart Richardson Deposition Services, 915 Main Street, Suite 304, Evansville, Indiana, on April 30, 2018 at 9:06 a.m., pursuant to the Federal Rules of Civil Procedure.

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INDEX OF DR. STOLTZ DEPOSITION EXHIBITS

(Dr. Stoltz Deposition Exhibits 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12 were premarked for identification.)

RANDALL STOLTZ, M.D.,

called as a witness by the Plaintiffs, having been first duly sworn, was examined and testified as follows:

EXAMINATION

QUESTIONS BY MR. PERAKIS

MR. PERAKIS: Let the record reflect this is a deposition -- an expert deposition taken pursuant to Notice and used for all purposes under Federal Court Rules.

Q Dr. Stoltz, my name is Harold Perakis. I represent the Estate of David Stojcevski in this matter. It looks like you've had some opportunity to understand what the case is about.

Have you ever been deposed before?

A Yes.

Q How many times?

A Once in the past four years.

Q Once in the past four years?

A Correct.

Q Okay. Do you remember the rules about speaking clearly, no nods of the shoulder or shrugs of the shoulder and so forth?

A Yes.

Q And because this is a phone deposition, I'll do my best not to interrupt you. I'll make sure that I take a few seconds. Let me take a few seconds of stopping my question before you answer. Okay?

A Okay.

Q All right. Now, I see that you have in front of you a couple of exhibits, right?

A Yes.

Q I assume you have a total of 12 exhibits in front of you?

A Yes.

Q Is that right?

A That's correct.

Q And the second exhibit -- yeah, the second exhibit is your CV, right?

A Yes.

Q Okay. And I know it's labeled differently than that, but it's a CV. So I'd like to go through that with you so I understand what your background is. Okay?

A Sure.

Q And what I'd like to do is start, really, at the back of your -- in the appendix, publication 1. All right?

A Sure.

Q I mean, Appendix 1, publications.

A Okay.

Q Are you there?

A Yes.

Q Okay. So I've looked at all these, and I guess I just wanted to get a sense of which of those publications -- I'll try to make this simple. Which of those publications have anything to do with benzodiazepine withdrawal?

A Well, technically, none of them have to do directly with that. I mean, the next to the last one, inhaled loxapine, is a benzodiazapine-type drug that -- as well as lorazepam that we actually looked at how long the drug stayed in your system and followed through a pharmacokinetic research trial -- drug trial, but...

Q Okay. So may I assume, if you're looking at the first -- Appendix 1, page one, if that's page five of six of your CV, may I safely assume then that nothing in those -- that those publications on the first page, are directly related to benzodiazepine withdrawal?

A No. You're -- you're correct.

Q Okay. So you won't be relying on that first page

of your -- of your appendix in any way, will you, in answering these questions today?

A No.

MR. CHAPMAN: Object to form and foundation.

Q So the answer is you will not be depending on those particular publications; is that right?

A That's right.

Q Okay. So let's go to the second page of your appendix. And I believe the one that you did mention and I noticed when I was looking at it, was -- it sounds like an interesting study that basically you were involved and three other doctors, possibly, and the quote is inhaled loxapine and intramuscular lorazepam in healthy volunteers: a randomized placebo-based -- or placebo-controlled drug-drug interaction study; is that right?

A Yes.

Q Okay. Now, first of all, you were talking about healthy individuals in that particular study, right?

A That's right.

Q You were not talking about people who were addicted to any medication, right?

A Correct.

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Q And you weren't talking about anybody who was possibly starving to death or had problems with being hydrated, right?
A That's right.
Q Okay. So do you believe that -- you know the facts of this case to a certain extent. Do you believe that David Stojcevski in any way reflects the patients that were in that study?
A No.
Q Okay. So may I now assume then that your entire Appendix 1 publications are not directly related to this case and you are not using -- well, number one, are not -- are not directly related to this case, right?
A That's right.
Q And also, you will not be using any of those publications in making determinations pertaining to this case, right?
A That's correct.
Q Okay. So now we can go back to the first page of your CV. Now, explain, Dr. Stoltz -- not that this is particularly relevant, but I was curious -- why is this on a Covance. Solutions Made Real document?
A Well, actually at the time of this CV, I worked for

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Covance. And actually they produced the CV with all my of background information, and then the CV was sent out to different pharmaceutical companies. We actually -- it went out for business. It was used for business development.
Q Okay. So -- and now, it's -- your first part of your employment history suggests that you worked -- you work with Cov- -- you're with Covance. Is it Covance? Is that right?
A Correct.
Q Okay. And you worked from 2005 to the present as medical director?
A Yeah. Actually my CV's changed as of the first of this year, but no, as medical director until -- they closed the business in Evansville last fall. So they're no long- -- I'm no longer with Covance.
Q Okay. So January 1st of 2018 you no longer worked for Covance; is that right?
A I believe that it was actually in October of '17 is when they closed the business here.
Q Okay. Well, let's just talk for a minute. Since October of 2017, without that employment, what have you been doing?
A I work for the Vanderburgh County Detention Center. And actually there's an additional one on -- not on

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this list is the Warrick County Detention Center.
Q You said the Warrick County Detention Center?
A Yeah, W-a-r-r-i-c-k, Warrick County Detention Center, as medical director of both of the jails.
Q Okay. So from October of 2017 until the present, you've been the medical director of two different correctional facilities?
A Well, I've been medical director for a long time in Vanderburgh County, since 1998, but actually in -- starting in January of '17 to the present I've been also the one at the Warrick County Detention Center.
Q Okay. So since January 2017 you've held two roles as medical director in two separate facilities; is that right?
A Correct.
Q And that would be Vanderburgh and Warrick County; is that right?
A That's right.
Q And because I noticed that Warrick County is not part of your CV here, may I assume that the bullet point under Vanderburgh County Detention Center would be a similar bullet point under a Warrick County Detention Center that describes your employment?

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A Yes.
Q Okay. And now, let's -- so we know what Covance -- we know that you worked for Covance for it looks like about 12 or 13 years, right?
A Right.
Q And during those 12 or 13 years at Covance, did you have any hands-on medical treatment with patients?
A Yes.
Q You did?
A Yes.
Q And can you give me an estimate of percentages? If you -- if you look at those whole 12 or 13 years, how -- what's the percentage of your clinical practice versus your administrative duties at that -- at that employment?
A Probably 80 to 90 percent clinical and 10 percent -- 10 to 20 percent administrative.
Q Okay. Can you define what you mean by the 90 percent clinical? What would you be doing -- what would you have been doing during that time?
A Well, I saw patients every day. We actually evaluate them to be in clinical trials and make sure they're healthy volunteers, look at laboratory tests, look at ECGs, whatever testing was involved to make sure they qualify for a clinical trial.

And once they were in a trial, we would follow them from a safety standpoint to make sure things were safe.
Q I see. So what you're talking about then is during those 12 or 13 years you were actually doing clinical trials with patients?
A Correct.
Q And did any of those clinical trials involve any type of drug withdrawal?
A Yes.
Q And how many of those percentage of the patients that you saw or you were -- you were doing clinical trials with involved drug withdrawal?
A I don't recall the exact number or percent. It's a low number, though.
Q More than 10 percent, do you think, or more than 20 percent?
A Oh, no. I'd say probably 5 percent or less. Probably less than 5 percent.
Q So what would the other 95 percent be?
A It would be new drugs and development for things such as diabetes, high blood pressure, hepatitis A, HIV, et cetera, et cetera, et cetera.
Q Okay. So if we sort of narrow this down, Dr. Stoltz, then what we're talking about is from

2005 until October of 2017 -- during the time that you worked at Covance, number one, you would have dealt with at most 5 percent of the patients had something to do with drug withdrawal; is that right?
A Correct.
Q And of that 5 percent of patients who were involved with drug withdrawal, what percentage of that had to do with benzodiazepine withdrawal?
A I'm thinking. Probably in the neighborhood of 10 percent.
Q Okay. So 10 percent of the 5 percent; is that right?
A Right.
Q Okay. And I guess I -- because I'm not real familiar with clinical trials, Doctor; I'm more involved in -- you know, in cases involving specific treatment of patients, can you explain to me whether the patients that you did see that involved benzodiazepine withdrawal, were those -- were those patients who were actively withdrawing from the medication, or had they been off of that medication for some time?
A In trial, if they were on a benzodiazepine or a similar-type product, they may be on it for seven,

ten days, and then they would be stopped. Sometimes they'd be tapered off; sometimes they'd just be stopped and then watched to make sure no signs of withdrawal occurred.
Q So these -- and I'm -- excuse me, I don't want to use the word, but I'm going to use it anyway. So were these people sort of guinea pigs for determining what was to happen to them once they were tapered off of the -- of the benzodiazepine; is that right?
A That's a term some people --
MR. CHAPMAN: I'm going to object to the use of the pejorative term guinea pig. That's really insensitive and way out of line, sir.
MR. PERAKIS: Well, it's a word that I've chosen to use, so...
Q And if you disagree with me, Dr. Stoltz, or you think it's pejorative, you can let me know that, okay, and I'll -- I'll use another one.
A I guess that's a word --
Q Okay?
A -- that Time Magazine used at one point on their -- on a cover page. But these are healthy volunteers that volunteered to be in clinical trials to test new products. And they were monitored very closely

in the trials for safety.
Q Okay. So once again, every patient that you've discussed that were involved in benzodiazepine withdrawal were healthy patients; is that right?
A That is true.
Q In other words, they were eating every day, right?
A Yes.
Q And did you pay attention to their nutrition during the trials?
A It depended on the trial. Some trials, there has to be strict monitoring of nutritional intake and calorie intake; other trials there's not.
Q Okay. But needless to say that when you were examining these -- and I guess I'll use them -- is it clinical subjects; is that better, or study subjects --
A Sure.
Q -- is that all right with you?
A Sure.
Q Okay. So in dealing with these study subjects, the thing that I'm having a little hard time understanding is, were you -- would you put them on benzodiazepines to determine what their -- what the impact of withdrawal was going to be?
A I would say there was a variety of reasons we would

study. And usually there's new chemical entities, new -- either new benzodiazepines or something like the study referred to, the loxapine or the -- similar products. It would be looking if there's drug interactions between the different products, look to see if -- that one study in particular was inhaled versus taking it orally. There's a difference in how it's absorbed in the body, how long it will stay in the body. And also you would look for, you know, side effects, drowsiness, et cetera. And you'd also make sure there's not withdrawal phenomenon.

Q And the reason that you would taper these individuals off of the benzodiazepines is because abrupt stoppage of benzodiazepine being prescribed would cause trouble -- would cause various problems with that particular study patient, right?

A Well, usually we did not taper them off; we stopped them abruptly.

Q Okay. So you would -- so what you -- go ahead.

A I said we -- we stopped them abruptly, but we would watch them for any signs of withdrawal.

Q Oh, I see. Okay. And were you able to determine what signs of withdrawal were common in these healthy patients?

A Well, you could see the same -- I mean, theoretically you could see the same thing in healthy people versus other people. It just depends on -- these people were on --

Q Well --

A New people to taking the drug, not people that have taken it chronically and then you suddenly stop them.

Q Oh, okay. So these people had not been taking benzodiazepines on a chronic basis, right?

A Correct.

Q Okay. So they were -- they were actually introduced to benzodiazepines through your studies, right?

A That's right.

Q Okay. And did any of these people have drug addictions?

A Not that they -- not that they admitted to.

Q Okay. Do you know if any of these people had ever been incarcerated?

A That's a question we ask when they come in for screening. And they -- they did not qualify for the trial if they had been incarcerated or had drug addiction problems.

Q Okay. So -- so, in other words, these were people

that were going through whatever they were going to go through outside of a correctional facility, right?

A That's right.

Q Okay. Doctor, I'm going to -- this question is not in any way meant to be derogatory of your -- of your studies. But do you feel comfortable in comparing those study people -- study patients with someone such as David Stojcevski?

MR. CHAPMAN: Object to form and foundation. I don't know what you mean by "comfortable."

MR. PERAKIS: Well, let's see if he knows.

MS. SWINDLEHURST: I'll join.

COURT REPORTER: Cara, was that an objection? I'm sorry, you cut out.

MS. SWINDLEHURST: Yeah. I'll join in the objection.

COURT REPORTER: Thank you.

Q Dr. Stoltz, would you like me to restate the question or have it reread back?

A Yeah, please.

Q What's that?

A Yes.

Q Yes?

A Yes.

Q All right. Dr. Stoltz, do you feel comfortable in utilizing any findings in those studies and using those studies in making decisions about David Stojcevski?

A Well, I -- I mean, I guess my comment would be I don't feel like there's a lot of relevance directly with his case.

Q Okay. And --

A Obviously, if we were using benzodiazepines, there's some information you obtain from when you do the -- we call them pharmacokinetic studies with benzodiazepines. It gives you some information on the half-life of the drug, how long it stays in your system. So I mean, there is some correlation but not direct correlation with David's case.

Q Okay. So then tell me why you believe there's not much relevance to David's case.

A Well, David --

MR. CHAPMAN: Wait. I'm going to object to form and foundation. I don't think those were the words he used. He said there's some correlation.

Q Doctor, do you want to answer the question?

A Yeah. Repeat that again.

Q You previously testified just a moment ago that there wasn't much relevance to your study findings

to David's case. Do you agree with that?
A Yes.
Q Okay. And tell me why you believe there's not much relevance.
A We tend to use the benzodiazepines in a different way than someone on the streets would use them in our research trial.
Q Well, when you say "someone on the streets," are you talking about people who were prescribed the medication by a doctor?
A Correct.
Q Is that yes?
A Yes.
Q Okay. So you're not -- that's -- you're not in any way being pejorative of David by using the term "on the streets," are you?
A No. Outside of our clinical research site.
Q Outside of your clinical research what?
A Outside of what we do in our clinical research. People outside of our research site tend to be -- it's a different situation.
Q Okay. Fair enough.
Now, when you -- when you have been studying these people, did you pay attention to the amount of dosage being used by these patients?

A Yes.
Q Did you also pay attention to how long the medication was being prescribed before they were abruptly stopped?
A Yes.
Q And did you also pay attention to the last time that those study patients used those medications?
A I'm not sure what you mean by that.
Q Oh, in other words -- yeah. In other words, you knew exactly when that particular patient began and ended the usage of the benzodiazepine, right?
A That is correct.
Q And Doctor, were those factors that I just mentioned important in determining the impact of the stoppage of the medication?
A They could be.
Q Why could they be?
A Benzodiazepines, depending on the dosage, depending on the half-life of the drug itself, can all be factors in if you're going to have any withdrawal phenomenon or side effect problems with the drug.
Q Okay. And so -- so the dosage matters then, right?
A Yes.
Q And so does the type of benzodiazepine, right?
A Correct.

Q Now, what if you add into that -- that mix of medications oxycodone, to prescribe oxycodone for pain at the same time a person is taking benzodiazepines?
A Potentially a dangerous combination.
Q It's a dangerous combination?
A Potentially a dangerous --
Q Is that what you said?
A I said, "Potentially a dangerous combination."
Q And would it be more dangerous if the patient was being prescribed two benzodiazepines along with an oxycodone?
A It sure could be.
Q And why is that?
A Well, there's warning labels on the drugs for using those combinations, especially two benzodiazepines together. In addition, you know, if you drink alcohol with it or other things you're mixing with those drugs, there's a chance for death.
Q Okay. So is it common knowledge, as far as you know, that -- that that triumvirate of medications is, in medical circles, deemed to be extremely dangerous?
A It's deemed to be dangerous -- potentially dangerous.

Q All right. And that includes the danger of death, right?
A Yes.
Q Okay. So you never had to deal with anybody in these studies, did you, that were taking oxycodone at the same time they were taking benzodiazepines, right?
A I don't believe so.
MR. MCQUILLAN: Guys, I think we're going to take a quick break for just a second.
MR. PERAKIS: Okay.
(A brief recess was taken.)
Q Continuing to look at what has been marked -- or that should be marked Exhibit 2 --
MR. PERAKIS: And I just want to make sure nobody had any objection to admitting that as Exhibit 2?
MR. CHAPMAN: I have no objection.
MS. SWINDLEHURST: No objection.
MR. PERAKIS: No objections? Okay.
Q So --
MR. CHAPMAN: Well, wait, wait. Let me think. I reserve any objections for trial. You can use any exhibits you want during the deposition. And I have no objection to you using them during the dep.

I reserve any objections that I might have at trial.

MR. PERAKIS: I think we all agree to that. I understand that, Ron.

MR. CHAPMAN: Okay.

MR. PERAKIS: No problem.

MR. CHAPMAN: Okay.

Q So the next part of your CV is you worked for West Pharmaceutical Services from '99 to 2005, right?

A Correct. And I can clarify that. Actually Covance bought West. So actually I've been with the same company for -- since two thousand- -- or since 1999.

Q I'm sorry. Oh, so Covance was the same as West Pharmaceutical?

A Covance purchased West in 2015.

Q Okay. Thank you. I didn't hear that. I'm sorry.

To try to cut this short, does any -- did any of that employment relate in any way to your opinions regarding David?

A It was the same information we discussed with Covance.

Q Oh, okay. So they were the same kind of studies, is what you're saying?

A Correct.

Q Okay. So the next one is Vanderburgh County Detention Center in Evansville, Indiana. And it looks like you've been the medical director since 1998; is that right?

A Yes.

Q And can you tell me what percentage of your involvement as medical director at that particular detention center involves clinical treatment and care of patients/inmates?

A Probably 99 percent is patient care. 1 percent's probably administrative.

Q 1 percent is administrative?

A Yes.

Q Okay. Now, I know that you had a chance to review some of the facts in this case. And do you believe that Dr. Sherman's employment was similar to your employment at Vanderburgh?

A From my understanding.

MR. CHAPMAN: I'm going to object to form and foundation.

A You know, honestly, I don't know exactly what his role was there. I would assume it would be similar. I think the jail is --

Q Okay. Well --

A -- a fair amount bigger there than it is here.

Q I'm sorry. Say that again.

A I think the jail where he was at was a fair amount bigger than the one I'm at.

Q Okay. And how big is the Vanderburgh County Detention Center?

A It's around 600 to 700 inmates.

Q Okay. Which is -- which is a little more than half of the capacity for the McComb County Jail, I believe.

So tell me what your duties were on a daily basis at Vanderburgh County Detention Center.

A Well, I respond to the nursing phone calls or texts on different issues; new inmates coming in, what medications they were on, treatment of diabetes, hypertension, different diseases and then seeing people on sick call, the ones that need to be seen weekly, similar to what other physicians probably do in other jails.

Q Okay. And during your time at Vanderburgh County, were you involved in the medical treatment of individuals with drug withdrawals?

A Many times.

Q Many times?

A Yes.

Q And of those many times, how often would it relate

to benzodiazepine withdrawal?

A I don't know the number offhand but quite a significant number.

Q Doctor, in terms of your Vanderburgh County Detention Center, is Evansville, Indiana, a small city or a large city?

A I would say a medium-size city.

Q All right. And would that mean there would be a couple hundred thousand citizens there?

A In the county, there's probably, I'm guessing, two hundred to 250,000 in the county.

Q Okay. Would you call Evansville, Indiana, an urban community where the detention center is?

A Yes.

Q Yes?

A Yes.

Q Okay. And do you agree that benzodiazepine withdrawal is a fairly common occurrence in the inmates that you see at Vanderburgh County Detention Center?

A I'm not sure I'd use the word withdrawal as common. I would say it's common people come in on benzodiazepines and we take them off.

Q And when -- and when they do come in on benzodiazepine withdrawals, the patients or

inmates, what is your -- what do you -- what do you do for them?
A If I know they're on benzodiazepine, if they tell us and we confirm it, depending on what the benzodiazepine is, how much the dosage is, we may start them on a taper -- tapering dose. We might put them on a monitoring protocol for withdrawal, that type thing.
Q Okay. So you're -- I can assume then you're familiar with the factors involved in determining whether inmates that come in on benzodiazepine -- what factors are involved in continuing them to taper off of that medication, right?
A Yes.
Q All right. And could you tell me what are the considerations in making that determination about whether to place somebody in a benzodiazepine withdrawal protocol?
A If I know they're taking benzodiazepines when they come in and they tell us at receiving the screening, whether they take it off-the-street drugs or they actually get it from a pharmacy under a doctor's prescription, we look at the -- which one it is, what dosage they're taking, how long they've been taking it and determine, based on

that, whether they are put on a tapering dose of benzodiazepines from day one or we put them on a protocol to monitor them.
Q Doctor, I know you mentioned that -- you talked about inmates who tell you during the screening process, right?
A Yes.
Q Well, what if some -- what if an inmate tells you, as David did, six or seven days after he -- after he is incarcerated that he's been on benzodiazepine withdrawal? What do you do then?
A Typically, if they've already been in, such as David, for a week, and then they finally tell us, they've already been on a monitoring protocol already. And if they're doing fine, there's no significant issues at that point. They're already weaned off their benzodiazepine.
Q Well, let's talk about that for a minute.
Do you have any evidence at all that David was put on a monitoring program for benzodiazepine before he told the staff about his use of those -- of that medication?
A He was put on a COWS protocol because he told them he was on opiates. But that's a similar -- similar kind of protocol where you're monitoring vital

signs and monitoring condition.
Q Well, but it's not the same, is it?
A Not exactly, no.
Q Okay. What is the difference?
A Well, there's different monitoring parameters. I don't have the protocol right in front of me. I think it's -- it might be one of the exhibits. But they're a little bit different parameters. But typically you would pick up issues on either one of the protocols.
Q How do you confirm -- once an inmate has told you that he's on certain medication, how do you confirm that he, indeed, is telling you the truth?
A That can be difficult to do.
Q Okay. Now -- yeah. Just, I guess -- I understand that, but can you tell me how you do it?
A Well, we ask them where do they get the medication, what pharmacy they go to so we can confirm, who's their physician. And if they tell us, we call and confirm.
Q Is that it?
A Well, if we confirm, say, from a pharmacy, we'll see when they last had the prescription filled; if they come in with a bottle, see how many pills are left. It just depends on the situation. Each

person's kind of individualized.
Q Yeah. And you do agree, don't you, that in making assessments about a particular inmate's risk of withdrawal is a very individualized decision, isn't it?
A Yes.
Q So if a doctor or a nurse utilizes a general -- general decision-making without considering the specifics of a particular inmate's medical care, that would be inappropriate, wouldn't it?
MR. CHAPMAN: Object to form and foundation.
A Well, I would say in general you use a general thought process and reasonable medical judgment for all the opiates and all the benzodiazepines. But if, in particular, you know which ones they've been taking, which ones are short acting versus long acting, which ones have higher withdrawal issues, you may individualize in that manner. But I mean, your COWS and your CIWA protocols, they're the same for everybody. They're not different protocols for different people.
Q Fair enough. But once again so we -- back to confirming the medication. Why is it important to confirm the medication dosage and duration of usage and the last time that it was used?

A Yeah. Unfortunately, that's not always -- it's very difficult to do many times. But ideally -- in an ideal word, if they come in and we know exactly what they're taking, the dose and when they took the last dose, then you -- like you said, we could individualize the treatment based on that.
Q Yeah, but I -- no, I understand, but I -- the question I asked was, why is it important to know the dosage, when it was last taken, the -- the duration of the -- of the use of that medication?
A To de- -- well, to decide if you need to put them on a withdrawal protocol or a withdrawal medication or you may not need anything at all. I mean, many people come into our jail and say they've been taking this, and we can't find any record of it, because they want drugs when they come into jail or alcohol, the same way. They'll say they drink a fifth of vodka a day and -- every time they come to jail. They've never withdrawn in the past. So it all depends --
Q Well, I guess -- well, here's what I'm going to -- I guess it's important that I ask you this question. Okay?
In simple terms, Doctor, other than knowing the pharmacy or knowing the doctor who prescribed

the medication, what other ways do you have to confirm whether the patient is telling you the truth about his medications?
A Well, depending on your state, I guess. Indiana has the INSPECT program. You can contact them to see if the person has been doctor shopping or pharmacy shopping.
Q You said it depends on your state?
A Correct.
Q Explain what you mean by that.
A Well, different states have different programs where you can contact -- Indiana has one called INSPECT. And you can contact them and it tells you individual patients that have been doctor shopping or patient -- or pharmacy shopping. If they filled OxyContin at ten different pharmacies in the past week, you could look that up.
Q All right. So how easy is it to look that up in Pennsylvania --
A I have no --
Q -- or excuse me, in Indiana? I'm sorry.
A It's time --
MR. CHAPMAN: Object to form and foundation.
Q How easy is it, as a medical director of a facility -- detention facility, to look up that information

in Indiana?
A It's time consuming.
Q What's that?
A It -- it can be time consuming.
Q Explain why it's time consuming in Indiana.
A You have to go online, put passwords in, get through the system. It takes --
Q Doctor, can you speak up? I'm having a hard time understanding what you're saying.
A Yeah. You have to go into a computer sys- -- be at a computer. You have to put in passwords. You have to go into the system. And it takes awhile to bring all the information up.
Q How long?
A I haven't done it for a while. It can take 10, 15 minutes.
Q Okay. So it takes 10 or 15 minutes to know how to handle an inmate, right?
MR. CHAPMAN: Object to form and foundation. That's not what he testified to.
A Yeah, that's a very broad question there.
Q Well, I know your -- I know your testimony said 10 to 15 minutes. Do you believe that's a long time to provide proper medical care?
MR. CHAPMAN: Object to form and foundation.

A I think it all depends on how -- how much you need that information. We don't do -- we don't -- do not do that on every inmate that comes into the jail.
Q I understand that. And -- but in a situation where you don't know specific facts that are important in determining whether a benzodiazepine withdrawal protocol should be implemented, don't -- doesn't a doctor have an obligation to find that information before he makes decisions about putting someone on a protocol or not?
MR. CHAPMAN: Object to form and foundation.
A What's more typically done is if you have a suspicion the patient is on a benzodiazepine, you put them on a benzodiazepine taper when they walk in the door, that way you basically protect the patient.
Q And that's because it's better to be safe than sorry, right?
MR. CHAPMAN: Object to form and foundation.
MS. SWINDLEHURST: I'll join.
Q Is that right?
A In some circumstances, yes.
Q Okay. So in some circumstances, it's better to be safe than sorry? Are you telling me not in all

circumstances it's better to be safe than sorry?
A I never --
MR. CHAPMAN: Same objection, form and foundation.
A I never say all.
Q Go ahead, Doctor.
A I never say all.
Q What's that?
A I never say all.
Q You never say all?
A No.
Q So -- okay. So let's assume for a minute that in Michigan there's a system called MAPS. Are you aware of the MAPS system?
A No.
Q It's called the Michigan Automated Prescription System. You've never heard of that?
A No.
Q Does Indiana have something similar in terms of the monitor that's used that you're talking about takes 10 to 15 minutes to find information?
A I presume it's similar to the --
MR. CHAPMAN: Objection to form and foundation. He said he doesn't know.
A I don't know.

Q What's that?
A I presume it may be similar to our INSPECT program, but I don't know.
Q To your I inspect [as said] program?
A I-N-S-P-E-C-T.
Q I-M as in Mary --
A I as in Indiana. I-N- -- N as in Nancy --
-S-P-E-C-T.
Q And what does that stand for?
A Indiana -- I don't -- honestly, I don't know what it stands for.
Q But you use it?
A Periodically. Our jail does.
Q Okay. Under what circumstances does your jail use INSPECT?
A That all depends. If we have someone we suspect is -- keeps coming in and out of jail and abusing drugs and shopping everywhere, we -- we may look them up to see what all physicians they're going to, what all pharmacies they're going to to confirm what they've been taking.
Q So is it -- is it your testimony that the only time you use the system called INSPECT is if you suspect that somebody's drug shopping?
A It's if we have questions about someone in

particular about what's going on with them and their background and drug use.
Q Okay. Doctor, is there another way to confirm medication usage, to talk to family members?
A Well, generally, if they're over 18, we can't do that due to HIPPA violations.
Q Can you ask the patient to sign a release to talk to family members?
A You could.
Q Is there anything that would stop you from doing that?
A I don't know.
Q Could you ask the patient if he remembers the next day after he didn't remember?
A You could.
Q Could you ask the day after that?
A You could.
Q Doctor, based upon your review of all the records, is there any indication whatsoever that anybody in the jail asked Mr. David Stojcevski if he recalls where the pharmacy was or the doctor that was involved at any time after June 18th of 2014? Excuse me.
A Yeah. I believe someone did on either June 17th or 18th. Mrs. Cueny --

Q Right. Well, let's -- okay. But other than that particular time that you're discussing, because we'll get into the date of that, but other than that time, is there any indication that anyone in the jail; medical staff, mental health staff, corrections officers did anything to try to confirm or verify that what David was telling you was the truth?
A Not that I recall.
Q Okay. Do you believe that a jail that does not follow up in making a continual attempt to talk to the patient about where he was getting the medication, do you believe that that falls below the standard of the medical staff?
A No.
MR. CHAPMAN: Object to form and foundation.
A No.
MR. CHAPMAN: I'm sorry. Was there an answer?
MR. PERAKIS: Yep.
A No.
Q You do not believe it is?
A No.
Q And tell me why.
A Once again, things are individualized for patients that come into your jail. If a person tells you,

such as David, a week later he's taken these drugs, you've already tapered him off. You've done the appropriate thing potentially anyway. You've not noticed any symptoms, any vital sign changes, any problems, it doesn't matter what he -- where he took it at; it's after the fact.

Now, it could have been important on day two or day three to know that, if you would have known that, but he didn't -- luckily he did not have any withdrawal symptoms the first six days after he came in. So we would not be -- in my jail, I would not be calling his doctor, calling the pharmacies. At day seven when he told, I think, Monica Cueny, about the drugs, we would not be calling to find out. It wouldn't matter at that point. He's already been tapered off.

Q Well, Doctor, can you tell me what symptoms exist for benzodiazepine withdrawal?

A Well, generally early on within the first few days you're going to have vital sign changes. You may have sensory changes. You may have, you know -- some kind of hallucinations are possible early on, but you'll not be totally right. And there's a list, you know, the CIWA scoring of the other different symptoms that they look for. But like I

said, David had already been monitored for a week before he admitted taking these other drugs.

Q What about tremors, Doctor?

A That's possible.

Q What about delusions?

A That's possible.

Q What about confusion?

A That's possible.

Q What about -- what about being nonresponsive in interpersonal relationships?

A That could occur.

Q What about loss of appetite?

A Many times, if they're going through the different symptoms such as what you mentioned, they may not think about eating as much as they would before. And so you may, you know, see that as appetite changes.

Q What about hallucinations? Did we talk about that already?

A That's a possibility, yes.

Q Okay. And you -- I think you mentioned -- what about -- you said a moment ago that it's possible that hallucinations could occur.

MR. PERAKIS: Is there a reason we're getting an echo now?

COURT REPORTER: Not that I know of.

THE WITNESS: Not on our end.

MR. CHAPMAN: This is Ron Chapman. I haven't done anything different.

MR. PERAKIS: Okay.

MS. SWINDLEHURST: Same.

MR. PERAKIS: Yeah. I'm just telling you there's a big echo going on.

(A discussion was held off the record.)

Q So what about seizures or seizure-like activity?

A That's a possibility.

Q Okay. Now, a few moments ago you testified to hallucinations and how they possibly could occur the first few days of withdrawal, right?

A Yes.

Q Can they also occur a week after withdrawal?

A That's a possibility. That's less likely, but I mean, it's a possibility.

Q It's a possibility? You've actually seen it, haven't you, Doctor?

A I'm not sure I've seen it in my jail.

Q Okay. But you agree that the medical literature suggests that benzodiazepine withdrawal can take -- symptoms can be for weeks or even months or years? You agree with that, don't you?

A Well, not symptoms of seizures and that type of thing, but I mean symptoms of increased anxiety, increased -- probably some of their symptoms coming back before they started on the benzodiazepines. But yes, the -- in the literature it does state that.

Q Okay. So you agree that each individual's reaction to an immediate cessation of benzodiazepine medication that has been prescribed, that each individual's responses are, in fact, individualized and have to be carefully monitored?

A Each -- yeah, each person responds differently to many medications.

Q Right. And what impact does the medication triumvirate of oxycodone, Xanax and Klonopin have on the possibility or likelihood that some of the early onset symptoms could last -- could occur much later in the week or in several weeks?

A Well, the oxycodone -- the narcotics get out of your system relatively quickly. And Xanax --

Q Right, I understand that.

A -- gets out of your system quickly.

Q But once again the question is there. Does that complicate the analysis of whether to put somebody on benzodiazepine protocol -- withdrawal protocol?

A I don't think so. You'd follow the same protocol either way.
Q Okay. So is it your testimony that if David were to have symptoms, they would have all occurred within a week of him -- of cessation of the medication?
A Obviously, no one has a crystal ball, but in general speaking terms, most people that come in on medications such as he mentioned will have most of their -- the worst symptoms within the first few days of the first week if they're going to have symptoms.
Q Okay. So most people most of the time, right?
A Yes.
Q All right. And the symptoms would have occurred within the first week of cessation; is that right?
A Yes.
Q Now, taking into consideration something that is part of the record in this case, in situations where there's a possibility or potential for benzodiazepine withdrawal, do you agree that it's better to be safe than sorry?
MR. CHAPMAN: Object to form, foundation, too general of a question.
MS. SWINDLEHURST: I'll join.

A So say that again.
Q Yeah. In a situation where there's even a potential of benzodiazepine withdrawal, do you agree that it's better to be safe and put the person on protocol, benzodiazepine withdrawal, than it is to allow him to die 10 or 17 days after he gets incarcerated?
MR. CHAPMAN: Same objection.
A Well, once again --
MS. SWINDLEHURST: Join.
A -- I would say it needs to be individualized from the history and the information you receive.
I mean, when David came in, there was no mention of benzodiazepines. And if there would have been and he had just taken the last pill before he came in that day, I would put him on a benzodiazepine protocol and probably withdrawal.
The way it worked out, he didn't tell them until a week later that he hadn't taken it for two weeks. And he would have been obviously withdrawing at home before he came in but even until -- even withdrawing more --
Q Well --
MR. CHAPMAN: Let him finish. Let the doctor finish.

A -- by the time they found out he was taking it. So I would not have put him on benzodiazepines at that point, no.
Q Dr. Stoltz, is there any indication in the record that you can show to me that indicates what the last dosage of Xanax was?
A Only in the record, I believe, with Monica Cueny on the -- I believe the 17th or 18th -- 18th, I believe, said he told her he hadn't taken the -- something for two weeks.
Q And what was it that that note says, if you could --
A I'm sorry. I can't remember --
Q And that -- and that would be --
A -- which Exhibit 2 that was.
Q -- in Exhibit 5 that's been marked. Are you looking at it?
A Yeah. It states the last dose of Klonopin two to three tabs at home last -- taken two weeks ago for anxiety.
Q I'm sorry. Could you --
A The middle of that exhibit in Monica Cueny's note, it states that he does take Klonopin, two to three times at home, last taken two weeks ago for anxiety, and patient unable to provide name or

location of the pharmacy.
Q Okay. So what was taken two weeks prior?
A It says Klonopin.
Q All right. So Doctor, you agree, don't you, that that same note only talks about Klonopin, right?
A Correct.
Q And that that was last taken two weeks ago?
A Correct.
Q For anxiety, right? Right?
A That's what it says.
Q Is that right?
A That's what he --
Q And doesn't -- does that note also confirm that Mr. Stojcevski, in fact, confirmed that he had had psychiatric hospitalization for that anxiety?
A In the past, yes.
Q Okay. What impact does that information have in relationship to knowing the seriousness of his condition and the seriousness of him needing that medication?
A Well, typically in jails and prisons we --
MR. CHAPMAN: Object to form.
A -- don't use benzodiazepines on people that have anxiety. But someone like David, he would be referred to mental health and have mental health

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evaluations done in my jail -- in most jails.
Q Okay. So there would be a mental health evaluation is what you're saying?
A Yes.
Q Okay. Now, going back to the question I asked you, is there any proof in the record whatsoever that suggests that anyone in the jail knew what the last time was that David was taking Xanax?
A No, but the good thing is Xanax -- I mean, from David's standpoint, Xanax tapers out of your body real quick, and usually you have withdrawals pretty quickly if you've been on Xanax.
And so even if he stopped it the day before he came to jail, he was on a protocol -- at least the COWS protocol where he's being monitored for five or six days, and he showed no withdrawal symptoms at that point.
Q Okay. And Doctor, I'm sure you've looked at the records pretty thoroughly. And is there anything in the record that David was experiencing the following symptoms during his incarceration: Sensory deprivation, hallucination -- well, let's just start with sensory problems.
A Well, it was noted when he -- in the mental health unit, he had withdrawal -- you know, social

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withdrawal, would not speak to folks. He was kept on observation. He was doing bizarre things such as hallucinations potentially.
Q Okay.
MR. PERAKIS: Folks, can you hold on just one second?
MS. SWINDLEHURST: Sure.
(A discussion was held off the record.)
Q So when you're defining sensory problems, you're including social withdrawal, right?
A Yes.
Q Is that right?
A Yes.
Q What about noncommunicative behavior?
A Yes.
Q What about unresponsiveness?
A It was mentioned in the record.
Q Okay. So next let's go to hallucinations. Is there anywhere in the record that suggests that David experienced hallucinations and/or delirious statements or behavior?
A Yes.
Q Is that yes?
A Yes.
Q Do you know how many -- do you know when that

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happened?
A I'd have to look at the actual date.
Q Yeah. I think if you look at Exhibit -- let's see. If you look at Exhibit 3 --
A Yes. Okay.
Q Do you see that note?
A Yes.
Q So I know that you're reading what I think you're reading, could you read it to me?
A On 6-17 from Vicky Bertram it says called to patient's housing unit at 1925 with complaints of being vaguely responsive, observed patient sitting on the floor, states that all his organs but 10 percent of his heart was removed and his arms shredded a couple days ago.
Q Continue.
A Oh. Patient states that it happened while he was here. Patient stated that he was taking drug -- taking four milligrams of Xanax daily for anxiety and oxycodones for pain.
Q Okay. So we know that that was placed in the record at 8:12 p.m. on June 17th, right?
A Correct.
Q Okay. And you agree, don't you, that that particular note would indicate delirium or

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hallucinations -- and/or hallucinations, right?
A Correct.
Q Okay. Is there anywhere in the record that confirms that David was suffering tremors or constant shaking?
MR. CHAPMAN: Object to form and foundation.
MS. SWINDLEHURST: I'll join.
A I'd have to look at the record more closely to see if -- I don't recall that being -- except for --
Q Have you had a chance to look at the video?
A No, I've not seen the video.
Q You've not seen the video?
A No.
Q So I can assume then that -- well, have you seen portions of it?
A No.
Q So you wouldn't know about the extent to which David was suffering tremors or seizures or any type of abnormal behavior, would you?
A Only what was in the medical record, and I did not --
MR. CHAPMAN: Object to form and foundation.
A I did not receive the video.
Q What's that?
A Only what was documented in the record. I did not

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receive the video.
MR. PERAKIS: Hang on one second. Yeah. You know, let's -- I do need to take five minutes, guys.
MR. CHAPMAN: Okay. Let's take a break.
MR. PERAKIS: Thank you.
(A brief recess was taken.)
Q Doctor, is sleep pattern disruption an indication of benzodiazepine withdrawal?
A It could be. You know, interestingly, I'll just comment at this point, you know, many of the things you mentioned of all of the different symptomatology is not just withdrawal symptoms. Those can all go along with mental health disorders as well, which, you know, in my opinion, is probably what's going on with this individual.
Q I gotcha. Now, what about -- is there any indication in the record that David Stojcevski was confused during his incarceration at McComb County Jail?
A I believe most of his symptoms --
MR. CHAPMAN: Object to form and foundation.
A Yeah. Some of those --
Q Go ahead.
A -- symptoms occurred on the 16th -- or 17th and

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18th. And he was even brought down to the medical unit. He was evaluated. And, you know, at some -- one or two points thought he was faking things.
Q Right. And Doctor, do you also agree that in the medical record that the -- that it was confirmed that David was suffering from decompensation on June 18th?
A Well, there was a question about that. And he was, I guess --
Q Well, it was noted in the mental health records.
MR. CHAPMAN: You need to let him finish his answers, please.
MR. PERAKIS: Oh, sure.
A Ask that question again.
Q Yeah. Give me one second.
On June 18th in the mental health observation initial assessment, the reason for watching David 24 hours a day, seven days a week was listed as decompensation. Do you -- could you please explain decompensation?
A Well, if mental health felt he was decompensating, that could be from a mental health disorder.
Q Could it also be from acute benzodiazepine withdrawal?
A Less likely since he had been off benzodiazepines

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for at least a week at that point and maybe even two weeks.
Q Well, I'm not asking you that. I'm asking you is it possible that it could also be a result of acute benzodiazepine withdrawal?
A (No response.)
MR. CHAPMAN: Object to form and foundation to the word "possible."
MS. SWINDLEHURST: I'll join.
Q Can you explain what decompensation means?
A Decompensation means mentally you actually become somewhat incapacitated mentally, which could be a variety of things when they use that terminology.
Q Well, okay. So tell me what those variety of things are for a moment.
A You could have hallucinations, auditory, visual. You could be -- have delirium. You could not be with it, so to speak.
Q So that means that all the things that you testified were symptoms of benzodiazepine withdrawal are the same things that -- what decompensation means?
A Could be -- yeah. It could be a mental health disorder underlying -- he could have underlying health -- mental health disorder that's

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exacerbating or getting worse.
Q Exacerbating what?
A Exacerbation of an underlying mental health disorder.
Q I don't -- I'm a little confused. I understand the concept of exacerbation, but --
A Worsening -- worsening of an underlying -- I mean, potentially his anxiety could be coming forth.
Q So in other words, he could be having an anxiety attack when they labeled him as decompensated?
A True.
Q And anxiety is one of the symptoms that benzodiazepine improves; isn't that right?
A Yes.
Q Is that yes?
A Yes.
Q Okay. So now back to other symptoms of benzodiazepine withdrawal. Do you recall anywhere in the record that confirms that -- and I think we've talked about this, but I'll say it anyway -- that David was nonresponsive to various stimuli in his little world in MHO1?
MR. CHAPMAN: Object to form and foundation and pejorative statements.
MS. SWINDLEHURST: I'll join.

Q Is that right, Doctor?
A I'm sorry. Read that back again. Everybody interrupted me.
Q Yeah. Is there -- is there evidence in the record -- medical record that confirmed that David was nonresponsive for many days during his stay in MHO1?
A Well, on 6-17 when --
MR. CHAPMAN: Object to form and foundation, mischaracterizes the record.
A Vicky Bertram saw him on 6-17. She said he complained of being vaguely responsive, observed him sitting on the floor, which we already read earlier.
Q Right. No, but what about the 18th?
A He was brought down to medical and evaluated after he would not -- he would lay in the floor twitching and brought down in a wheelchair. And after being evaluated, he walked back without -- with a steady gait.
Q And Doctor, you agree, don't you, that one of the significant symptoms of benzodiazepine withdrawal is that the symptoms actually wax and wane, right?
A Well, the times I've seen them in the past, they tend to progressively get worse many times if you

don't treat them.
Q They get progressively worse if you don't treat them; is that what you said?
A They can. They don't tend to just come and disappear.
Q Yeah. Did you look at the video --
A I did not.
Q -- to determine -- or wait. Let me ask you this. Did you look at the medical -- the mental health records pertaining to what they deemed was David's nonresponsiveness?
A Yes.
Q And you saw that almost every day from the 18th till the 27th, the date of his death, in fact an hour and a half before he died, mental health staff was claiming that he was refusing or non- -- refusing to speak to them or nonresponsive, right?
A Well, I saw in the -- initially at some point they came by, and he asked about getting his medications. When they did not give him medications, he refused to talk to them and stayed away from them and kind of avoided them ever since, it appeared to me.
Q Well, do you know what day that happened, Doctor?
A I'd have to look exactly on the record to see for

sure what date that was.
Q Well, if I tell you it was the 21st and it was the only time he did that, do you agree with that?
A That sounds about right, yes.
Q Okay. So is there anywhere in the medical records that demonstrated or showed evidence that David had a loss of appetite?
A I believe that somewhere I saw he was not eating. I'd have to look in the record and see exactly dates and times for that.
Q Yeah. I believe, in fact, there is no monitoring of what he was eating, was there, Doctor?
A I don't think directly.
MS. SWINDLEHURST: Object to form and foundation.
MR. CHAPMAN: Join.
Q Okay. So your answer is, is you don't see anything in the medical records to suggest that he had a loss of appetite, right?
A Not that I recall.
Q Okay. Now, what about -- do you recall in the records whether David was suffering from any seizure or seizure-like activity?
A I do recall -- I've got it here in front of me. One second. Well, Dr. Sherman ended up seeing him

because he was called -- or he was observed in the medical unit for questionable seizures.
Q Yeah. And do you know what Dr. Sherman testified to or is in the record said about those seizures?
A Well, he says in the record I observed him fluttering his eyes and what was certainly not a seizure, but it was mostly a poor attempt to fake one.
Q So Dr. Sherman felt that he was faking the seizures?
A According to his note on --
MR. CHAPMAN: Object to form and foundation, mischaracterizes the record.
Q Let me use the word then. Did Dr. Sherman believe that he was feigning seizures or that his seizures were being feigned?
A The one he observed that he wrote in his progress note on 6-24, I think it occurred on 6-17 when he saw him.
Q Well, Doctor, I just want to point you to your -- page four of your record -- of your report. I'm sorry. You, in fact, used the term that Dr. Sherman believed that he was -- that David was trying to fake a seizure, right?
A Yes.

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Q Are you looking at your report?
A Yes.
MR. CHAPMAN: Where are you pointing to on page four?
MR. PERAKIS: It's page four of the second paragraph. Do you see that, where he starts with he evaluated him for possible seizures?
MR. CHAPMAN: The second paragraph that starts out Dr. Sherman added a late entry?
MR. PERAKIS: That's right.
Q Do you see that, Doctor?
A Yes.
Q Is that yes?
A Yes.
Q Okay. Yeah, you need to speak up, Doctor. I can't hear you.
A Yeah, I'm right next to the phone. I'm not sure why, but okay.
Q Do you see where it was your word -- the word fake that was used in your report, right?
A Yes.
Q So is it your testimony that Dr. Sherman suspected seizures -- suspected faking seizures?
A That appears from the note.
Q Dr. Stoltz, is there anything in the medical record

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to confirm that Dr. Sherman ruled in or ruled out his suspicion that David was faking a seizure?
A Well, I'm -- from reading his record, in his, you know, best medical judgment at the time and observing David and then when he shook his shoulders, things stopped, with a seizure, that's not going to happen.
Q I under- -- I understand that, but I -- that's not the question I asked you.
Is there anything in the medical record written by anyone that suggests or evidences that Dr. Sherman attempted to rule in or rule out his suspicion that the seizures were fake?
MR. CHAPMAN: Object to form and foundation.
MS. SWINDLEHURST: I'll join.
A My only comment would be on Dr. Sherman's note that his impression was a feigned seizure behavior and return to general population without seizure precautions. He did not feel that he had seizures.
Q I understand that. But you do agree, don't you, that an important obligation of a doctor in the correctional care -- in a facility, it's important and a clear obligation of the doctor to confirm whether the faking was occurring or not, right?
A And that's why --

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MR. CHAPMAN: Object to form and foundation.
MS. SWINDLEHURST: I'll join.
A And that's why he had a medical evaluation of David that day; he felt that it was not a seizure.
Q What's that?
A That's why he did a medical evaluation that day, for questionable seizures. He did -- that's what he did. In his best medical judgment, he felt he was not having seizures.
Q Do you know whether he did a medical examination on the 17th?
A Well, from his entry note and then from his testimony in his deposition he said he did. That's all I can go by.
Q But Doctor, is there anything in the record that says that he did an examination?
A Only his note on 6-24 he entered.
Q What's that?
A Only in his note that he entered --
Q What's that?
A Only in his note that he entered in the --
MR. CHAPMAN: You've got to let him answer. You can't keep interrupting him.
MR. PERAKIS: I'm not -- I can't hear him, Ron, that's all. I'm not trying to interrupt him.

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MR. CHAPMAN: Well, okay.
MR. PERAKIS: I really am not. I just can't hear what he's saying. Okay? I'm sorry about that.
MR. CHAPMAN: Okay.
Q So would you -- do you want to restate your answer?
A Only in the record that he documented on 6-24-14 and in his deposition that he evaluated him.
Q I understand that. So what you're telling me is that -- that the only thing in the record is his note that he supposedly wrote on the 24th, right?
A Right.
MR. CHAPMAN: Object to form and foundation, mischaracterizes known evidence.
Q Now, we know that Dr. Sherman said certain things in his deposition, right?
A Yes.
Q And do you agree with everything he said in his deposition?
MR. CHAPMAN: Objection. It's a memory test -- not a memory test.
MR. PERAKIS: Oh, you don't -- if he can't answer it, that's okay.
A I don't -- actually, I don't recall everything in the deposition offhand right now.

Q Okay. Well, Doctor, I'm a little bit concerned about your failure to answer a very simple question. Did we know that his -- that Dr. Sherman's examination resulted in a conclusion -- resulted in a conclusion from Dr. Sherman that he suspected that David was faking a seizure, right? We know that from his examination, right?
A I can only look at the record on -- that he entered on 6-24-14 where he says impression: Feigned seizure behavior, return to GP without seizure precautions.
Q Right. So that was his conclusion? In other words, he suspected feigned seizures or faked seizures, right?
A Correct.
Q Now, at the moment he told him to go back to general population, going forward during the next ten days of his life, did Dr. Sherman in any way rule in or rule out that those seizures were fake?
A I don't believe --
MR. CHAPMAN: Object to form and foundation, asked and answered.
A Yeah, I already answered that.
Q Okay. So your answer is exactly what you said before, right? And in other words, what you're

telling me is the only thing that he did to determine whether the seizures were fake is his examination? Is that what you're telling me?
A Yes.
Q Is that yes?
A Yes.
Q Can you say that a little louder for me?
A Yes.
Q Thank you. And I think you need to speak like that because I'm real serious? I'm having a hard time hearing you. All right? You might be talking into your papers; I'm not sure.
MR. CHAPMAN: I'm sorry. If I could intervene for a second, I think Counsel's correct, Doctor. Maybe -- I don't know. I note the phone's volume -- sometimes you're very loud, and sometimes you're not. If you could maybe -- I don't know what we can do, a better effort or something, but -- but I understand what Counsel's saying. You're a little difficult to hear sometimes.
THE WITNESS: I'll move it right in front of me. Is that any better?
MR. PERAKIS: Yeah. I think that's the best thing we can do, Doctor. I appreciate that.
THE WITNESS: Okay.

MR. PERAKIS: Give me one second.
Q Doctor, going back to the issue of Xanax, isn't it true that Dr. Sherman did nothing to confirm the dosage of Xanax, the last dosage that was taken or the duration of the Xanax that was being taken?
A Well, at the time Dr. Sherman was made aware of that, the inmate was already off of the Xanax for a week, at least that we know of. So I mean, he would have already been going through withdrawals, most likely, from Xanax before that point. So there would be no reason to necessarily have to find that out. Who cares?
Q So what you're telling me then is that Dr. Sherman had no reason whatsoever to address the issue of Xanax?
A At that point there's --
Q Is that what you're saying?
A At that point you can put in the record he may have taken Xanax; you don't know, but it would not have changed the outcome or how he would have treated him at that point.
Q The question I'm simply asking is, did he do anything to determine dosage, duration of dosage or last usage of Xanax?
A And my comment is no, he did not, but there's not a

reason to do that. At that point it would not make any difference in how you would have treated him or managed him, other than refer him to mental health for mental health evaluation, which I would have done the same thing.
Q Okay. And once it's determined by a doctor or his staff or the mental health staff that David is, in fact, decompensating after he was allegedly feigning seizures, what's a doctor to do in that situation?
A Get a mental health referral.
Q Are you telling me that the doctor has no other obligation than to let mental health take over?
A Well, I would get a mental health referral for an evaluation. And if they say I don't think it's anything mental health going on here, I think it's more medical, then the medical folks would get more involved at that point.
Q Well, I understand that. But we know that he was decompensating, right, as of the 18th?
A Well, interestingly, on the -- I think it was the 17th and 18th he had these weird symptoms of heart coming out, this and this and this, but that never recurred days after that.
Q So are you telling me that delusions or

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hallucinations have to keep recurring before anybody's put on benzodiazepine withdrawal protocol?
A Well, I think if he was having true benzodiazepine withdrawal, things would have got progressively worse, and he would have had a lot more symptoms progressing on days later. And he actually became coherent. He would talk to the nurses, in the record, talk to mental health until he didn't get what he wanted. So I mean, in my --
Q Do you know whether his physical and/or mental condition deteriorated after June 18th, 2014?
A Well, he had vital signs done, I believe, on three separate occasions after that, and they were all stable. The nurse came by and saw him and talked to him at times. But, obviously, he did go downhill the last two or three days before he passed away. But once again --
Q Was anything -- did medical get involved at all during those last two or three days?
A I believe the last -- he had a set of vital signs on the 25th that were normal. But I believe they felt he had an underlying mental health problem. And, unfortunately, he would not speak to mental health. But I'd probably refer more of that

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evaluation to a -- maybe a psychiatrist expert rather than myself.
Q Doctor, if I tell you that the only involvement that medical had with Mr. Stojcevski during the last four days of his life was a 30-second nurse visit, would you agree with that?
MR. CHAPMAN: Object to form and foundation. It mischaracterizes the record.
MS. SWINDLEHURST: I'll join.
A I don't know how long the visit was. I just saw vital signs recorded on the 25th.
Q Okay. And so vital signs answers the whole question; is that what you're telling me?
A I just said that was recorded.
Q I understand that. But do vital signs tell the whole story about whether somebody is going through benzodiazepine withdrawal?
A Not necessarily.
Q Okay. Then tell me why it's "not necessarily."
A I mean, there can be a lot of things involved. Obviously, if someone was decompensating from opiates, benzodiazepines, you typically see changes in vital signs as part of the process.
Q Well, I understand at least you say you typically see it. They didn't see it this time, did they?

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A No.
Q Do you know how many times the nurses have claimed to have done -- have taken vital signs but they were never recorded?
A I did see a note that the nurses said they -- when they made rounds, they did record them. If they were normal, they may not necessarily write them down.
Q So how are we to know whether the nurses are telling us the truth about his vital signs?
A Well, I look at the ones that were recorded.
Q Okay. So you're not depending on any of the unrecorded vital signs, right?
A No.
Q Can you tell me what date or dates Dr. Sherman saw David?
A I believe just 6-17.
Q What document are you looking at that tells you that?
A It is the provider progress note on 6-24-14. And through the deposition it said it was actually information recalled from his visit on 6-17.
Q Oh, so you have to supplement the notes with the deposition testimony in order for you to determine that he saw him on the 17th; is that right?

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A Well, that and the nurse's note that they refer him to the doctor on the 17th as well as --
Q Right. Are you aware that Mr. Stojcevski was taken down to the medical unit on June 23rd because he had pooped and urinated on himself in his jail cell?
MR. CHAPMAN: Object to form and foundation. That's not specified.
MS. SWINDLEHURST: I'll join.
Q Are you aware of that?
A I don't recall that exactly, no.
Q Well --
A Is that one of the exhibits?
Q -- I want you to -- I want you to take a careful look, if you will, at what you're looking at, which is Dr. Sherman's note. Do you see that? It's Exhibit 6.
A Right.
Q Do you see that?
A Yes.
Q So the date of service is June 24th, 2014. You agree with that, right?
A That's what the progress note says at the top. However, it says an added, by Dr. Sherman, late entry for 6-23. And I read in one of the

depositions of how this computer system, if you don't close out a note, it will date different dates. So I couldn't tell you for sure what date that was.

Q Okay. So -- so really -- I just want to make sure you agree with me at least, that this particular note doesn't really confirm -- does not confirm that Dr. Sherman saw him only on June twenty- -- June 17th, right?

A You can't tell from his note.

Q You can't tell from this note? And whose fault is that?

A It could be the computer system or just documentation.

Q Or it could be Dr. Sherman's fault, right?

A It could be just the way he documented things, correct.

Q Is there anywhere in that note that confirms that he did a medical exam on David?

A Only on the entry from Bey-Shelley on 6-17 that he was being sent back to the unit after the physician completed the assessment.

Q I understand that, but that's -- even Bey-Shelley only says completed the assessment, right? It doesn't say he did an exam?

A Well, I presume when you say completed assessment, it includes a full assessment, an examination and plan of attack.

Q Well, I understand that's what you want to presume, but is it a fact?

A I can only say what's in --

MR. CHAPMAN: I'm going to object. What's the question? What's the question? Is what a fact? Doctor, hold on. What's the question?

Q The question is this: Is there anywhere in the note that you're looking at, which is Exhibit 6, that suggests that there was a medical examination of David Stojcevski on June 17th --

MR. CHAPMAN: It's been asked and answered.

Q -- by Dr. Sherman?

MR. CHAPMAN: It's been asked and answered. Objection.

Q And what's your answer?

A I said from the progress note on that page alone, Exhibit 6, I could not say for sure.

Q All right. Is there anywhere in that note that confirms that he performed a neurological exam?

A Not from looking at the note itself.

Q Okay. Could you please tell me what it means to be oriented times three in a neurological exam?

A It means you're oriented to person, place, and time.

Q So if we look at this note, there's no proof that David was oriented to place, time, and person, is there?

A No.

Q Is that no?

A Not from that note alone, no.

Q Not from that note alone. So the question I have for you is, if we don't know by this note that he was oriented to time, why would a doctor depend on his assessment of time in terms of when the last medication was taken or not taken?

A Well, you know, it could not have been taken anytime after the 11th because he was in jail.

Q That's -- I agree with you there. Okay?

A So the doctor would know he's not been on medication at least for six, seven days no matter what.

Q I understand that. But we still don't know when his last dosage of Xanax was done, right? In fact, Dr. Sherman didn't know that, did he?

A No. But once again, like I said earlier, it would not matter. You've already basically had him on withdrawal protocol and observation for six days

without significant symptomatology feeling there was any withdrawal issues going on.

Q Did you notice in the records that Monica Cueny actually believed and stated in her note that he should continue on the protocol, and that was on the 18th?

MR. CHAPMAN: Object to form and foundation.

Q And I'm going to direct you to Exhibit 5.

A That's what -- I was looking at that.

She noted that. I'm not sure -- I -- I was recalling in her deposition -- I think she thought he was still on that protocol, but he had finished that protocol at that point.

Q Well, actually you agree, don't you, that he had finished that protocol three days earlier, right?

A Right.

Q And if Nurse Cueny had made any attempt in looking at medical records, she would have noticed that there was a jail memo that confirmed that he had finished protocol, right?

MR. CHAPMAN: Object to form and foundation. It's an intentional mischaracterization of the record.

MS. SWINDLEHURST: I'll join.

Q Well, Doctor, are the COWS assessments in the

medical record?
A Earlier, yes.
Q Is that yes?
A Earlier.
Q Earlier, yes?
A Yes.
Q So if Nurse Cueny had taken the time to look at the records, the fact that she -- that the COWS protocol were there would have been easily identifiable, right?
MS. SWINDLEHURST: Object to form and foundation.
MR. CHAPMAN: Object to form and foundation. Again, it's a mischaracterization. You know they weren't there then. Don't mischaracterize things in order to gain an advantage. It's not pretty.
MR. PERAKIS: Well, they sure -- they sure better have been since they --
MR. CHAPMAN: No, they shouldn't have. And you know the explanation for that and the fact that they weren't there. You just can't mischaracterize things and trying to trip up the doctor.
MR. PERAKIS: Ron -- Ron, it's a vague --
MR. CHAPMAN: It's not fair.
MR. PERAKIS: It's a vague explanation, I

understand. Okay?
Q But what I'm asking you is very simply, Doctor, do you have any proof that the COWS protocol assessments were not in the medical records on June 18th?
A I don't know.
Q All right, Doctor. Have you found any evidence whatsoever that Dr. Sherman reviewed medical records involving David prior to making a decision on not to institute a benzodiazepine withdrawal?
A I don't know that from looking at the record.
Q Well, Doctor, can you explain, as a doctor, why it's important to have accurate and timely recordation of a patient's care or treatment?
A Well, to accurately evaluate and manage a patient, you like to have all the information about that patient; medical history, medical allergies, medications, diagnoses, past hospitalizations, surgeries, et cetera, et cetera. And unfortunately, when folks come into jail situations that information can be very difficult to get ahold of. Patients will tell you things that -- they'll hide things from you. They'll lie about things many times, and you may have inaccurate information. So you have to go on your best

judgment on how a patient feels, how he looks when you do your receiving screening and your evaluations.
You know, unfortunately Dr. Sherman did not have the information about benzodiazepines when Mr. -- or when David came into the jail. And it wasn't until a week later that he got some information about that. At that point, he'd already been tapered off, so to speak, and did not feel anything further needed to be done. And that was actually in the -- the note from Monica Cueny after she'd contacted Dr. Sherman.
Q Okay. So once again, let's get back to the importance of medical records. Do you agree that medical providers, nurses and doctor, should look at the medical record of an inmate whenever he is -- he is being -- whenever that particular medical provider is treating him?
A Ideally, if it's available, yes.
Q What's that?
A In an ideal world, yes.
Q Well, you know, that's the second time you've used the term "ideal world." What does that mean, Doctor?
A Well, if you're in a jail -- I mean, I've been out

when you get called into booking to see someone. I don't have a medical record with me when I go into booking to see someone, or I may see someone down the hall or here and there. I don't have their medical, and I don't have a chart with them. It's all an electronic system. So it depends on if that's readily available at the time you're evaluating someone.
Q So if it's not readily available when you're evaluating somebody, you just don't look at it? Is that it?
A You may go back and look at it later, but at the time -- it's like if you go to your doctor's office, my guess would be your doctor sits in front of the computer while you're seeing your doctor. And he's looking at your record and talking to you at the same time. It would be nice if that would happen all the time in a jail, but it doesn't.
Q Okay. So let's say you don't have time to do it on the moment you're examining them but you have time later. Is it important to go ahead and look at the records after -- after that examination?
A If there's information you need to know to treat that person, yes.
Q How would you know if there's information necessary

to treat the patient unless you've looked at the record?
A By what's going on at the time with the patient.
Q So what you're telling me is that your treatment only involved the moment that you're examining the patient? Is that it?
A It's so -- my comment would be it's very individualized on each individual situation. And it's in your best medical judgment what you need at that time. A physician or even a nurse would say I need to look at the medical records -- before I give penicillin, I better look at the record to make sure there's no allergies. You know, before I give this drug, I better see what other drug this person is currently on so I don't have a drug interaction. If I need this, I need to see the record. If you feel at the time I don't need the medical record to treat what's going on, I don't go back and look at the record, I treat the condition or I evaluate the condition.
Q So does that mean that a doctor's medical judgment takes precedence over protocols pertaining to benzodiazepine withdrawal?
MR. CHAPMAN: Object to form and foundation.
A A doctor has to use his best medical judgment to

determine does this person need benzodiazepine withdrawal or a protocol or whatever. That's their judgment.
Q All right. Do you know whether Dr. Sherman ever looked at any medical records at the time that he -- either before or after he examined David on the 17th?
A I don't know.
Q Do you know whether Dr. Sherman ever looked at medical records before or after Monica Cueny consulted with him pertaining to Mr. Stojcevski --
A I don't know.
Q -- on the 18th? On the 18th? You don't know, do you?
A No.
Q Should he have?
A He's getting the history from the nurse, and I don't see where -- how it would change how he would treat the patient at that point. He may have asked the nurse -- or the questions on the phone, I'm sure they did, but I don't see why he would necessarily have to go look at the medical record. I get these phone calls at home all the time. I don't have the medical records in front of me and no access to them from home.

Q And I understand. I understand that, but you know, I'm going to ask you to take a look at Exhibit 3.
A Okay.
Q Do you have it in front of you?
A Yes.
Q You agree that that was -- the date of service of Ms. Bertram, the LPN, was June 17, 2014?
A That's what it states.
Q Right? That's what it states. You also agree that she wrote this note in her -- in the medical record on June 17th at 8:12 p.m., right?
A Correct.
Q You also agree then that that note was in the medical records at least 16 hours before his conversation had ended with Ms. Cueny?
MR. CHAPMAN: Object to form and foundation. You haven't established that he knows the process yet.
Q Okay. Go ahead and answer the question.
A I don't know the exact timing before or after, but it was in the record, apparently.
Q Well, we -- it was in the record on the 17th, right?
A That's what it appears to be, yes.
Q And that was before Dr. Sherman consulted with

Nurse Cueny, right?
MR. CHAPMAN: Object to form and foundation. You haven't established knowledge yet.
Q And I'll direct you to Exhibit 5.
A Okay.
Q Do you see that?
A Yes.
Q Now, do you know that Nurse Cueny testified that when she put it in -- when she put the note in on the 18th, even though it was appended, that note was available to everybody who wanted to look at it?
A Okay.
Q Are you aware of that?
A I didn't look back at her deposition to verify that, but that sounds reasonable.
Q Okay. And that's because you understand medical records -- electronic medical records, right?
A Right.
Q And you see that that conversation that Dr. Sherman and Ms. Cueny -- and Nurse Cueny had was on the 18th, right?
A Correct.
Q And you agree with me then, don't you, that Nurse Bertram's note was on the 17th, the day

before the conversation had between Dr. Sherman and Nurse Cueny?
A Yes.
Q So Doctor, do you also agree with me that within a 24 hour time frame, Dr. Sherman learned about Xanax, Klonopin and seizures and hallucinations and did nothing, right?
MR. CHAPMAN: Object to form and foundation. This is -- wait. Object to form and foundation, mischaracterizes the evidence regarding seizures.
MR. PERAKIS: Okay. Then I'll restate it. So I'll restate it.
Q So isn't it true that Dr. Sherman, within a 24 hour time period, was aware of David taking Xanax, Klonopin and having hallucinations?
A Yes, and Dr. Sherman evaluated him as well during that time period.
Q Well, Dr. Sherman saw him on the 17th, right?
A Right.
Q Okay. Hold on a second.
Well, you agree, don't you, that on the 17th, when Dr. Sherman saw David, that he had no information about Xanax, Klonopin or hallucinations?
A True.

Q So do you believe any of that information should have, at a minimum, caused him to reconsider the conclusions he reached on the 17th?
A Well, his evaluation on the -- I mean, from a physician's standpoint, his medical evaluation on the 17th was based on an earlier note that day by Bey-Shelley, after she was called to the mental health unit, to refer the physician to see him for an evaluation.
Q So once again, I'm going to ask that question, that on the 17th when he examined David Stojcevski, he was unaware of David's prescriptions for Xanax, Klonopin and the fact that he had had hallucinations? Is that correct?
A Well, according to the notes --
Q Is that correct?
A -- he found that out from Cueny on the 18th.
Q You said -- your answer was that he found it out from Cueny on the 18th?
A That he had been taking Klonopin.
Q Right. And that -- what about seizures? What about hallucinations?
A I don't know from the record if he saw Bertram's note or not. I don't know.
MR. CHAPMAN: Excuse me. Objection. What's

your question? What about hallucinations? What about what?
Q Doctor, if Dr. Sherman had looked at the note from Ms. Bertram, he would have known about Xanax and he would have known about the hallucinations, right?
A He could have seen her note, yes.
Q Do you know if Dr. Sherman looked at her note --
A No, I don't.
Q -- looked at Ms. Bertram's note? What's that?
A I don't know. And I would say from a physician's standpoint, it would not have made any difference if he knew she was -- he was on that or not. Now, if he would have actually thought he had true seizures, that might have been a different story.
Q Well, you just talked about seizures; you didn't talk about hallucinations, right?
A No.
Q So if the hallucinations had been there, along with the information about taking Xanax and Klonopin, don't you agree that Dr. Sherman should have reevaluated his prior decision that David was faking something?
A That's hard to say retrospectively. I mean, I would hope Dr. Sherman evaluated him on the -- the day he did and looked at all options. And,

obviously, he was in the mental health unit being evaluated mentally.
Q Doctor, so you would agree, wouldn't you, that the Vicky Bertram note was readily available to Dr. Sherman if he had looked at the note, right?
A I don't know for sure of that, no.
Q Why do you say that?
A I'm not a hundred percent sure how the CCS, Correct Care Solutions, computer system works and what's available and what timing and where Dr. Sherman was at the time, if he was in front of the computer, had access to it. I don't know all the circumstances of that moment in time.
Q Okay. So your answer is you don't know?
A I don't know.
MR. PERAKIS: Okay. Give me just a minute.
MR. CHAPMAN: Can we take a bathroom break for a second? Thank you. Going off for a bathroom break.
COURT REPORTER: All right.
(A brief recess was taken.)
Q You know, just so I have a better understanding of what's going on during the break, are you and Mr. Chapman talking about the testimony at all during your breaks?

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A I've been going to the bathroom, but I talked to Kevin for a minute.
Q What did you say? You talked to Kevin for a minute?
A Yeah.
Q What did you talk about?
MR. MCQUILLAN: I think we're going to object to attorney/client privilege.
MR. CHAPMAN: Wait a second. Doctor, wait, wait, wait, wait. Unless you ask a more specific question, Federal Rules of Evidence 26 prohibits his communication with you. There's only two very specific questions you can ask, and that's it. Unless you ask them, I direct the witness not to talk to you.
Q Did you talk about the case?
MR. CHAPMAN: Objection. Don't answer the question, Doctor. You have to ask very specific questions to obtain information.
MR. PERAKIS: Well, I'm going to ask the questions, and if you don't believe that it's appropriate, that's okay.
Q Are you taking any direction from defense attorneys in relationship to your testimony?
A I use my own testimony.

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Q What's that?
A I use my own testimony.
Q Do you take -- are you taking direction from Mr. Chapman not to answer questions?
MR. CHAPMAN: I'm not sure I understand your question. I just gave two on the record for him not-to-answer questions. What are you referring to?
MR. PERAKIS: Well, okay. So I presume, Ron, that the answer is yes, he was taking direction from you to not answer questions. Is that right or not right?
MR. CHAPMAN: Well, I don't know if that's right or not. I told him not to answer two questions, and he didn't answer them.
MR. PERAKIS: All right. So I think he can answer the question. He can answer the question.
Q Did you take direction from Mr. Chapman to not answer the question?
MR. CHAPMAN: What question are you talking about?
MR. PERAKIS: The one that he wouldn't answer.
MR. CHAPMAN: Look, we're going around in a ridiculous circle. On the record I directed him not to answer the question. So if you're asking

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him is he listening to Mr. Chapman, he did because he didn't answer the question.
MR. PERAKIS: Well, let him say that.
MR. CHAPMAN: I don't understand what you're doing here.
MR. PERAKIS: Well, let him say that.
MR. CHAPMAN: Why does he have to say that? He didn't answer the question.
MR. PERAKIS: Because it's his testimony, not yours, Ron.
MR. CHAPMAN: No. When I direct him not to answer, it's my statement, not his. He's my witness. I told him not to answer those two questions, end of story. That's not his testimony; that's my statement. And I'll suffer the consequences if the Court disagrees with me, but you didn't ask the right questions under Rule 26. So he doesn't have to answer those questions.
MR. PERAKIS: Okay.
Q Okay. All right. So Dr. Stoltz, if the Bertram note that we talked about from the 17th was available to Dr. Sherman, do you believe the information in that note would have been valuable to Dr. Sherman to know?
A Well, from my understanding, when Monica Cueny saw

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him, she actually reviewed that as well as reviewed all the information and did a thorough evaluation of David and gave all that information to Dr. Sherman, which he actually included in the use of the Xanax, Klonopin, et cetera. But he used that information to determine that no new orders needed to be done and to keep him in medical health evaluation, high observation.
Q So it's your understanding that that's the case?
A From their depositions, yes.
Q Are you telling me that it's your understanding that Nurse Cueny said that she had told Dr. Sherman about Xanax?
A She related information in her thorough -- she did a pretty thorough evaluation -- in her note to Dr. Sherman.
Q Well, where does -- where in the record do you see anything that suggests that Dr. Sherman was aware of Xanax and hallucinations from the Bertram note?
A I don't see it from the Bertram note.
Q Oh, so you believe that somehow Ms. Cueny communicated the facts of Xanax and hallucination to Dr. Sherman on the 18th?
A I believe from her depo- -- information in her deposition, yes.

Q Are you aware that in her deposition she had testified that she could not recall whether he discussed -- she discussed Xanax or hallucinations with Dr. Sherman?

MR. CHAPMAN: Object to form and foundation, mischaracterizes her total record.

Q Are you aware of that?

A I'd have to look at all of the deposition --

Q What's that?

A -- to determine for sure.

Q I can't hear you, Doctor. I'm sorry. That low voice has hit me again now.

A Yeah. I think at some point in the record she felt she did notify Dr. Sherman of that information.

Q So you think in her testimony she did say that?

A I'd have to look back at the record to verify at what point she mentioned that and as well as what Dr. Sherman -- his --

Q Well, assume for a minute that there's nothing in her testimony that says that. All right?

MR. CHAPMAN: Well, I would object as continually misleading. It's -- I would object as continually misleading and inappropriate hypothetical because there certainly is.

MR. PERAKIS: Okay. Well, we'll get her

deposition, and we'll demonstrate to you that she doesn't recall.

Q So is it your testimony then that you believe that Dr. Sherman had, indeed, taken that into consideration in deciding not to institute benzodiazepine withdrawal?

MR. CHAPMAN: Objection. Take what into consideration?

Q Do you -- is it your testimony that Dr. Sherman took into consideration the information that existed in the Bertram deposition in making a decision to not institute a benzodiazepine withdrawal?

MR. CHAPMAN: I'm going to object to form and foundation. Again, what information? You have to be specific.

Q Okay. So looking at Exhibit 3, is it your testimony that the evidence of delusions was somehow transmitted to Dr. Sherman by Ms. Cueny?

A (No response.)

Q Can you answer the question, Doctor?

A I was looking at her note to verify.

Q Okay. Are you talking about -- you're looking at Monica Cueny's note?

A Correct. From the note alone, I can't tell you

everything she discussed with Dr. Sherman.

Q That's -- I'm glad you're saying that because it's clear that the note doesn't identify anything that Ms. Bertram put in her note, right?

A From the note, that's true.

Q Okay. So the only possibility that Dr. Sherman could have been aware of that fact would have been through his discussions with Monica Cueny, right?

A Yes.

Q Because -- or he looked at -- or Dr. Sherman looked at the notes, right?

A He may have looked at the note. True. I don't know.

Q Right. Okay. So that's one of the two options. But it is either/or, right?

A It could be both.

Q Is that right? Well, I understand that, but we know from this note that this note doesn't indicate that Cueny ever said anything to him about what Bertram had found the day before, right?

A It's not in the note.

Q What's that? Not in the note. Thank you.

By the way, going to Exhibit 5 -- and you're looking at Ms. Cueny's notes, how important is the fact that he had -- that -- how important is the

fact that Ms. Cueny confirmed that he had actually had hospitalization for anxiety?

A I'm sorry. I missed the question.

Q What's that?

A What was the question?

Q Oh. Is it an important fact that David had been hospitalized for anxiety --

A It could be.

Q -- in terms of determining whether he needed the benzodiazepine withdrawal protocol?

A Well, no, that's not -- I do not feel that's important for that. It's important for mental health referral, because obviously he had underlying mental health issues.

Q Okay. Dr. Stoltz, do you have Monica Cueny's deposition there?

A No. I actually have it on a disc -- on a flash drive. I don't have it in front of me.

Q Okay. Well, can you look at it?

MR. CHAPMAN: I don't believe there's a -- there's a computer there for him to plug it into.

Q Are you guys trying to pull it up?

A We're going to try.

Q Are you there?

A We're going to try.

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MR. MCQUILLAN: I can get the condensed. We have the condensed version that will -- that's loaded.
MR. PERAKIS: Okay.
Q May I direct you to a page?
A Yes.
Q Page 108. Are you there?
A Yes.
Q Okay. So it would be lines 3 through 7. And if you could just read the question in line 3 and then answer what her answer was. Out loud. I'm sorry.
A It says, Question, so regardless, that's not accurate. But regardless, you never discussed with Dr. Sherman your testimony, and that is that you did not discuss with Dr. Sherman anything about Xanax or anything about hallucinations, correct? And she says I -- I can't recall my exact words to Dr. Sherman.
Q Okay. That ---
MR. CHAPMAN: Under the rules -- wait a second. Under the rule of completeness, I request, that the entire page be read all the way up to 109 line 2, the complete understanding for the witness before you cross examine him on the statement.
MR. PERAKIS: Okay. We'll go -- we'll go all

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the way through 110, in fact. Okay? So go to -- if you'd go to look at page 110 for me.
MR. CHAPMAN: You want him to just read it so he understands it be- -- that's my question. If you want him to read it into the record, then do it now. I want him to read, for rule of completeness, so he has understanding of the context of this statement, at least to be able to read it to himself before you ask any questions.
Q Okay. Well, here's what we'll have you do, Doctor. Go ahead and read pages 109, 110, 111, and 112. Okay?
A Okay.
Q Take your time.
MR. CHAPMAN: So Doc, take your time to read pages 108 through 112, is what they're asking you to do.
MR. PERAKIS: Yes, that's exactly right.
MR. CHAPMAN: Do you have any idea how long we're going to be? If we're going to be another seven hours, I need to take a lunch break.
MR. PERAKIS: Oh, no, I don't think so. I think probably another hour, hour and a half.
MR. CHAPMAN: Okay. That would be good. Thanks.

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MR. PERAKIS: Okay. I'm going to try. I don't think that it's going to be another five hours or four hours, so...
Q Let me know when you're done, Doc.
A I think I'm done enough.
Q So I'll just -- we'll go back to page 108, right?
A Yep.
Q And the question that -- that you asked -- that was asked by Mr. Ihrie, and her answer was I can't recall my exact words to Dr. Sherman, right?
A Correct.
Q Is that true?
A Yes.
Q Okay. Are you getting it? Do you see that?
A Yes.
Q Okay. So then we go to page 109, and at 109 when asked at the bottom of 108, did you discuss with Dr. Sherman -- well, you've already testified that what you told Dr. Sherman -- that none of what you testified that you told Dr. Sherman included the word hallucination or Xanax or anything that is in Vicky Bertram's note, correct? That you say you looked at. Answer, I did talk about Xanax use and Klonopin use. Question, Now your testimony is that you are now recalling that you did talk to

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Dr. Sherman about David's Xanax use; is that correct?"
A Yes.
Q Her answer was, though, "From what the chart says, two days ago he said that" -- and then there was a long interruption and lawyer stuff. And at page 110 Mr. Ihrie asks "Xanax is not mentioned in your note, is it?" Answer, "No." "And you testified that you told Dr. Sherman everything that he told you, correct?" Answer, "Yes." "And then I asked you did you tell them anything else, and you said just what he told me." And then the next question, at the bottom of 110, "Is now your testimony that you did discuss Xanax and hallucinations with Dr. Sherman?" And her answer is, "I can't recall. I can't recall that. I can remember talking to him about Xanax and Klonopin, how he was on -- he reported Xanax one day and Klonopin another day." "So you did tell Dr. Sherman that he had reported taking Xanax on the 17th." "Um-hum." "Yes?" "Yes." "And Klonopin on the 18th?" "Yes." "So to the best of your knowledge, Dr. Sherman was fully aware on the 18th, after talking to you, that David had been taking Xanax and Klonopin." Answer, "That David had reported." "Yes." "Yes."

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All right. Now, down to page 112. "Since you told Dr. Sherman" -- this is line 3 -- "according to your testimony, about the Xanax, which you only could have learned from Bertram's note of the day before --" "Um-Hum." "Yes?" "Yes." "-- did you also tell him about the hallucinations?" "I can't recall."

So the question becomes is there any evidence that Cueny talked to Dr. Sherman about hallucinations?

MR. CHAPMAN: Other than what you just read in the record?

MR. PERAKIS: Yeah, including what's in the record.

A According to her information --

MR. CHAPMAN: Well, I object --

A -- she can't recall.

MR. CHAPMAN: -- to form. In the record she said she talked to him and she doesn't recall, so I don't understand what your question is.

Q Well, Dr. Stoltz, you agree that she doesn't know whether --

MR. CHAPMAN: Let him answer the question. You can't ask another question -- you can't confuse him. Come on.

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MR. IHRIE: Ron, if you have an objection, make it. No talking objections.

MR. CHAPMAN: There's no -- this isn't an objection. Because you read something and then you ask a question, I don't know what you're referring to.

Q Okay. Here, a simple question, Dr. Stoltz.

MR. CHAPMAN: Even the doctor --

Q Dr. Stoltz, where in the testimony did Monica testify that she told -- that she recalled telling Dr. Sherman about Xanax and Klonopin -- or Xanax and hallucinations?

MR. CHAPMAN: Objection. Ms. Cueny's testimony stands for itself. It doesn't need interpretation by the doctor.

Q Well, Doctor, you -- Doctor, you've testified that you believed that she did tell him, right?

A In her note, she states that when she evaluated him, there were no auditory hallucinations or visual hallucinations observed at this time.

Q Say that again?

A In her note she states there was no auditory hallucinations or visual hallucinations observed at this time.

Q What -- what --

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A On 6-18.

Q But you don't know whether Nurse Cueny told Dr. Sherman about Bertram's note, do you?

A I can't be for sure what all she explained to him.

Q Is there anything in her deposition that confirms that she talked to Dr. Sherman about hallucinations other than the fact that she can't recall?

A (No response.)

MR. CHAPMAN: I'm going to object to form and foundation.

MR. PERAKIS: Okay.

Q Just please answer the question, Dr. Stoltz.

MR. CHAPMAN: I think he just answered.

A I did just answer it.

Q What's that?

A I did answer it.

Q You did answer it? And what was the answer?

A Could you read it back?

MR. CHAPMAN: Objection, asked and answered.

Q What was the answer?

A I said something to the effect I could not tell from her note or from her deposition a hundred percent all -- all of what occurred during the conversation other than the fact --

Q Okay.

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A -- she was told --

Q That's --

MR. CHAPMAN: Let him finish. Let him finish. You can't cut him off because you don't like what he says. Let him finish. You can finish, Doctor.

A Yeah. Other than the fact that he was on benzodiazepine, he noted, as well as taking oxycodone and at the time she evaluated when she did a quite thorough evaluation, he had no hallucinations going on at the time.

Q Right. But that doesn't -- that doesn't address what Bertram stated in her note, right? Right?

A I can't tell from -- like I said, all what was -- during the conversation.

Q Right. Okay.

A You know, I would add that she did mention, you know, case discussed with Dr. Sherman. Generally, when nurses put that in their note, I mean, that the full case was discussed with the physician over the phone, they don't go into the extreme details of every word that was discussed. They go over, you know, I discussed the case with the doctor, so the doctor knows what's going on, till he -- so he makes his opinion on what he's going to do.

Q So I just want to make this clear. We don't know

whether Nurse Cueny told Dr. Sherman about hallucinations, right?
A We don't know for sure.
Q Okay. And Dr. Stoltz, is it true that the information that was in Ms. Bertram's note was available for Dr. Sherman if he had looked at it?
MR. CHAPMAN: Object to form and foundation.
Q Correct?
A It's possible. On the other hand, I would also add that when it says case discussed with Dr. Sherman by Monica Cueny the next day, that most likely that was all discussed.
Q Well, I -- and I understand your -- that's a presumption, and it's not based on any facts in the record, right?
A You could -- a lot of things you could presume in any case, I guess.
MR. CHAPMAN: Is that a question?
Q So, Doctor, is it your testimony that Dr. Sherman finding out within 24 hours that David was taking Klonopin, taking Xanax and experiencing hallucinations and delirium, that it's your testimony that that should not have triggered a benzo withdrawal protocol or at least another evaluation with Dr. Sherman?

A Well, in my opinion, he was just seen by Dr. Sherman just the evening or afternoon before with an evaluation done. And at that point he did not feel that there was anything significant medically going on and put him back in general population, and the next day -- the next morning a full thorough evaluation was done again by Monica Cueny, which, in her documentation and her notes, much better than what Dr. Sherman's was. There was not really a reason why he would need to go back and do another examination if she just did one. He -- she was -- he was stable at that time. She reported all the information to him, and they kept him in mental health, high observation, which sounds appropriate.
Q So what you're telling me then is it was -- that information was not important enough to trigger a reconsideration of his prior June 17th opinion or at least another examination?
A He had just evaluated him the evening before -- the evening before --
Q What's that?
A -- or the same day he had that hallucination thing you're referring to.
Q Say that again.

A I said he'd just evaluated him on the 17th. And you're referring to the note -- let me see here.
Q I'll direct you to Exhibit --
A Yeah. Go back to Exhibit --
Q -- 3, I believe.
A Yeah. He was -- he was seen the 17th by Dr. Sherman in the afternoon. In the evening, that's when Bertram evaluated him. And then Cueny did a thorough evaluation the next morning and referred all the information back to Dr. Sherman. I think that's appropriate. That's what we would do in my jail, and I would make decisions based on that information.
Q Well, but -- but you're talking about based on that -- that information. We don't even know if he knew about hallucinations, do we?
A Well, he's getting -- he's in the mental health unit and getting mental health evaluations, so that's the right place to be.
Q So let's talk about in your report -- I believe it's your conclusion that the medical staff of CCS was not deliberately indifferent; is that right?
A Oh, I -- I believe they actually --
MR. CHAPMAN: You're asking him for a legal conclusion when you ask him that

question. (Indecipherable.)
COURT REPORTER: Could you please repeat that objection?
MR. CHAPMAN: That's a legal conclusion, deliberate indifference.
MR. PERAKIS: Well, I'm going to --
Q I mean, it's in your report, right, Doctor? And let me just start off by saying something so I get this correct.
Looking at your report on page two and going to page three, you agree, don't you, that your opinions today and in your report are based upon the records that you reviewed, right?
A Correct.
Q Is that right?
A Yes.
Q Okay. So -- so I just wanted to make sure because on your opinion on page five in two different locations you basically state the same thing. First paragraph page five, "In my opinion, based on my education, training, and experience (especially in Correctional Medicine), I do not feel that the medical staff acted with deliberate indifference to David Stojcevski's care." Do you see that?
A Yes.

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Q And then at the bottom I believe you say something very similar where it says "In my professional opinion, and based on my education, training, and experience, I do not believe that the Correct Care Solutions medical staff acted with deliberate indifference or reckless disregard for the health or safety needs of Mr. Stojcevski."
Can you please define the term "medical staff" for me in those two opinions?
A The -- the nursing staff and the physicians, Dr. Sherman.
Q And so what you're talking about then is the -- once again, as you've testified, it would be Dr. Sherman and the nursing staff, right?
MR. CHAPMAN: Objection, asked and answered.
Q Is that right?
A Them as well as the mental health staff that was seeing him as well.
Q As well as the mental health staff, okay. So now that we have, in your opinion, you've defined medical staff as the -- Dr. Sherman, the nursing staff and the mental health staff, right?
A Correct.
Q Okay. Right off the start here, Doctor, are you familiar with what the mental health staff was

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doing after June 18th in their -- what they were writing in their notes?
A Yes.
Q And do you agree that in about eight days in a row their notes are almost identical, the basic message being we can't assess this guy, right?
MR. CHAPMAN: Object to form and foundation, mischaracterization.
Q Do you agree?
A Well, in other words, he would not --
Q What's that?
A -- he would not -- after he was not given the medications he wanted, he withdrew from wanting to speak with the medical staff -- I mean, the mental health staff.
Q Okay. Well, for whatever reason, they could not assess him, correct?
A Not thoroughly, no.
Q Well, what -- well, please define the term "thoroughly."
A Well, to give him a full mental health evaluation, it's hard -- other than looking at someone, it's hard to get much in the evaluation if he won't speak to you when you say how are you doing, what's going on, that type of thing.

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Q So how many days did that go on?
A I'd have to look at the exact number of days in the record. But I believe it got to where they had a care conference, I believe it was on the 26th, and --
Q Oh, so are -- so you are aware of the care conference?
MR. CHAPMAN: You can't interrupt him when he's answering questions. Come on, gentlemen. Let him fully answer.
Q So you are aware of the care conference, eh?
A I was aware a care conference came about on the twenty- -- I believe the 26th and then to get a psychiatrist involved, which an appointment was made, but he passed away prior to that evaluation.
Q Okay. So how long did it take before -- how many days was it between the first date that he was not able to be assessed and June 26th?
A I wouldn't say completely unassessed because medical saw him, I believe, two or three different -- I actually think three different times during that time period, as well as mental health --
Q I'm talking about days. How many days, Doctor?
A Well, mental health was seeing him, I believe, on the 18th till the care conference on the 26th.

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Q So that would be the 18th, 19th, the 20th, the 21st, the 22nd, the 23rd, the 24th, the 25th, and the 26th. So you agree with me, don't you, that it took nine days before anybody in the mental health department decided for him to see a psychiatrist? Is that what your testimony is?
A I was looking here.
MR. CHAPMAN: Are you asking him to confirm your math?
MR. PERAKIS: I just want him to answer the question.
MR. CHAPMAN: Well, but it's not his testimony. If you want him to count the days, he can tell you that. But the way your question is asked, it doesn't make sense.
MR. IHRIE: Make an objection, Ron.
Q So Doctor, can you answer the question?
A If that's the math, that's the answer.
Q Okay. So is it your testimony that mental health did assess him from June 18th till June 27th?
A They observed him in the mental health unit on suicide watch.
Q Well, right. I'm not asking you that question. I'm not asking you that question. We know they observed him through the door of the jail, right?

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You know that, right?
A Right.
Q But the question I asked you is, did they assess him --
A They.
Q -- from a medical -- a mental health perspective, because it's your testimony that they did everything right.
A They assessed him to the best of their ability. If he's not going to communicate and cooperate, you can't do much.
Q Well, wait a minute. You just testified that to the best of her ability, she waited till June 26th, after not being able to assess him for nine days, to refer him to a psychiatrist, right?
MR. CHAPMAN: Is there a question?
A That's when the care conference was set up.
Q What's that?
A That's when the care conference came about to discuss what we were going to do with this gentleman.
Q Well, I understand that. I understand there was a care conference on the 26th. Okay? And we'll talk about that. Well, what about all the prior days? Are you telling me that they were not deliberately

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indifferent for nine days even though they failed to have any assessment of this man from a mental health perspective? Is that your testimony?
A They have in the record --
MR. CHAPMAN: I object to use of the term -- wait, wait, Doctor. I object to the use of the term deliberate indifference. If you want to say standard of care, reasonable, but you're just setting up to make an argument in front of the Court. He can't testify to that fact. Ask him something more specific. Come on.
Q Well, Doctor --
MR. PERAKIS: Wait a minute. Let me just say this for the record. It's in his report. Everything is open to examination because it's in his report. So that's what we're doing.
MR. CHAPMAN: It is, but if you asked the question and move later to have the question stricken because he's given a legal conclusion, you're asking him to do that. And I'm asking you not to ask him to do that.
MR. PERAKIS: I'm not asking --
MR. CHAPMAN: Ask him to standard of care, reasonableness. You are.
Q I'm asking you the same question, and I think I'm

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going to have to --
MR. CHAPMAN: That's my objection. Do what you want to do. That's my objection. Go ahead.
MR. PERAKIS: Okay then. Bye, Ron. Fair enough.
So Court Reporter, could you reread that back to me?
COURT REPORTER: Yes, sir.
MR. PERAKIS: Do you know what I'm talking about, Court Reporter?
COURT REPORTER: I think I do. Let me search back here. Just a second, please.
(A discussion was held off the record, and the requested material was read back by the court reporter.)
Q Now, please answer, Doctor.
A Well, from the record, they did daily assessments. They had daily notes put in that they went by and saw the individual. Medical went by on multiple days and did vital signs and encouraged fluids.
Q Well --
A So I mean, he was not left --
MR. CHAPMAN: Let him finish. You have to let him finish. Come on.
MR. PERAKIS: Okay. I'm sorry.

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A Well, I was going to say --
MR. CHAPMAN: Well, you keep doing it. Let him finish.
A So I mean, there was some evaluation done the best that they could do. And it got to a point they finally, obviously, you know, decided to have a case conference on what to do next, but he was not left there with nothing done to him.
Q So once again, Doctor, are you telling me that they were not deliberately indifferent during the nine days that they -- their own forms say they could not assess him and they waited nine days to determine that a psychiatrist needed to be involved?
A Well, what I'm -- I'm not making --
Q Is that your testimony?
A I'm not making up a legal conclusion, but I'm saying that he was evaluated or looked at daily by mental health. And actually medical went in and did vital signs on him several days during that time period and evaluated him as well, and his vital signs were stable. He just refused to communicate and interact with the mental health people. Not much you can do --
Q So the question is -- so the question is, how many

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days were they going to wait before they needed a full psychiatric assessment of this man?
A Well, I'm not a psychiatrist to be able to tell you how long you should wait with somebody with this state of mind, whether he had catatonia or had something else going on. At what point do you do further action? I'm not a psychiatrist to tell you what length of time that is.
Q I know you're not a psychiatrist, but you have testified and you have confirmed in your report that the mental health staff were not deliberately indifferent.
A They -- and my opinion is they went by and saw the individual. Now, whether an individual would interact with them or not, that's -- that's one thing, but they did not avoid the individual. They went by and saw David on a daily basis. They have notes in their mental health notes they did. He would not interact.
Q And we're going to --
MR. CHAPMAN: You've got to let him finish, sir.
MR. PERAKIS: Okay.
Q Doctor --
MR. CHAPMAN: Finish, please, Doctor.

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Q Okay. Go ahead.
MR. CHAPMAN: Let the doctor finish. You can't interrupt him while he's giving an answer because you don't like the answer he's giving. Let's stop this stuff or I'm going to call an end to the dep. You do it regularly, and you can't do it when you don't like the answer.
MR. PERAKIS: Ron, Ron, half of the time I can't understand what he's saying, and I -- and I tried to make that clear, okay, so --
MR. CHAPMAN: That could -- that could be true, but then wait till he's done and say you don't understand, and the court reporter can read back the answer because she's getting it.
MR. PERAKIS: Fair enough. Okay. That's a deal. All right.
Q So do you want to answer the question, Doctor?
A I thought I just did.
Q Okay. Well, do you have the self-harm watch/mental health observation initial assessment?
A Is that one of the exhibits?
Q It's dated June 18th.
A Just a moment.
Q Let me know when you -- if you have it or if you don't.

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A We're looking.
MR. MCQUILLAN: Oh, you know what, hold on. You said the 18th?
MR. PERAKIS: What's that? The 18th. That's the -- the statement is -- it's called self-harm watch/mental health observation initial assessment.
A Yes.
MR. MCQUILLAN: We have it.
Q Do you have it?
A Yes.
Q Do you see the -- at the top the type of watch is self-harm watch. Do you see that?
A Yes.
Q Frequency every 15 minutes, right?
A Right.
Q And then on this particular document it says the reason for watch has been -- is decompensation. Do you see that?
A Yes.
Q All right. Now, in assessing somebody's mental status, is it important to know whether that patient is oriented times three?
A That can be part of your assessment, yes.
Q Is it also important -- now, I'm asking if it's important, and I know it can be part of the

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assessment, but is it important?
A Yes.
Q Is it important that -- when you know whether the person is alert -- the patient is alert?
A Yes.
Q Is it important that you know whether the person is distractible?
A Well, could be.
Q And what about poor concentration? Is that an important aspect of doing a mental status?
A It could be.
Q So you see -- under the mental status you see that Mrs. Brock writes other -- checks "other," right? Do you see that?
A Sensorium, other.
Q What's that?
A Where it says sensorium?
Q Yeah, for sensorium.
A Yes.
Q Do you see that she does that and underneath she explains, unable to assess, right?
A Right.
Q And you see all the way down, except for appearance, Ms. Brock says unable to assess? Do you see that?

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A Yes.
Q Okay. And when it comes to his appearance, she says patient was observed lying on lower bunk with rapid eye movement. Do you see that?
A Yes.
Q So here's what we have on this particular document, Doctor, and tell me if you -- if this is accurate. In this particular document, on June 18th we know he's decompensating and as a consequence he's being watched every 15 minutes? You agree with that, right?
A That's what it says.
Q Okay. But you agree with it too, right? That's what -- that's what the document reflects, right?
A Yes.
Q And it also reflects that the patient was on the floor lying on the lower bunk with rapid eye movement. Do you see that?
A Yes.
Q What's the significance of rapid eye movement; Doctor, in relationship to somebody who's decompensated?
A It's hard to say.
Q All right. Could it be that it relates to sensorium difficulties?

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A It could be.
Q Okay. Could it be that it relates to agitation?
A It's possible.
Q Could it be that it relates to delusions?
A Well, it could be a whole lot of things. It could be the guy's going into some, you know, mental health other issue, you know. And I believe actually that the mental health had medical come see him that same day. That's when Monica Cueny evaluated him.
Q Right. And what did -- and let's go back to Monica Cueny for a minute before I continue on. Okay?
A Okay.
Q If we go back to Monica Cueny's note, which is the same day -- and we've determined that she was in his bunk about 2:45 p.m. based on the video -- we note that she goes through everything that we've talked about, right?
A Right.
Q And then she concludes -- and then she concludes continue with COW protocol as ordered. Do you see that?
A Yes.
Q Did she do that?
A We talked about this earlier.

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Q No, I understand. But was COW protocol instituted as she -- as she believed was necessary?
A Well, I -- I would have to go back and look at her deposition again, but I believe she thought it was still ongoing at that time.
Q I understand that.
Was COW protocol initiated --
A He had put the --
Q -- regardless of whether it had been completed or not?
A It was not reinitiated, no, although he had vital signs done multiple times after that point. And interestingly, even from her note after mental health had this same note, she notes, you know, the guy does not have -- when she approached him, he began to flutter eyes open and closed. But then things obviously changed, and then he started, you know --
Q Yeah, yeah. I don't -- I don't know what medical records you're looking at, Doctor, to confirm that vital signs were taken. You agree, don't you, that body weight is a vital sign in CCS records, right?
A They generally do that on intake.
Q What's that?
A Most places do that on intake when they first come

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into the jail, either verbal or off their driver's license, or they wait depending on if they have a scale.
Q That's not what I asked you.
MR. CHAPMAN: You can't interrupt him. Come on, gentlemen. He's in the middle of the answer. You don't like it, so you interrupt him. I'm getting really irritated here because you're attempting to disrupt his thinking and it's wrong. Stop it.
MR. PERAKIS: It's hard to do it -- it's hard to do it, and I'm not trying to disrupt his thinking. This is not --
MR. CHAPMAN: Well, you are, and it's interesting. You always do it when he's giving you answers you don't like.
MR. PERAKIS: Okay. All right. So --
MR. CHAPMAN: Let him go back and finish, regain his thought process. Come on.
Q Okay. Finish.
A Well, my comment was, yeah, weight is usually checked on admission and either by verbal or off the driver's license or off a scale, if there's one in the receiving and screening area, but usually not repeated unless there's a reason to repeat

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that.
Q Okay. But I just want to -- I want to make sure you've noted something in these notes -- in these records.
Do you agree that weight is a vital sign throughout CCS's records?
A Well, it's placed on their progress note in their electronic medical record as well as pulse oximetry. You don't do those every time you see somebody.
Q I understand that. But you agree, don't you, that weight is a vital sign -- a patient's vital sign in CCS records, right?
A Well, if you're saying is it listed on the vital signs -- patient vitals on their progress note, it's built into their progress note --
Q Yeah.
A -- on the electronic record, yes. Just in case you check it, you can enter it.
Q Okay, okay. All right. So now we have Ms. Cueny who doesn't check, apparently, whether COWS protocol had ended, so she goes ahead and says continue COWS protocol, right?
A That's what it says in her note.
Q What's that?

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A It says that in the note.
Q It says that in the note. Okay. Now, I want you to read to me the last sentence of -- in Ms. Cueny's notes.
A Continue with low bunk status. Medical staff to continue to monitor for changes.
Q Okay. The last sentence says medical staff to continue to monitor for changes, right?
A Right.
Q What does it mean from your perspective -- since you have opined that the medical staff has done everything -- has done things that were not deliberately indifferent, tell me after June 18th what the medical staff did to monitor for changes that David was going through?
A I'd have to look at dates, but I believe on three separate dates they went in to check on him, do vital signs on him, which were stable, and --
Q Okay. Show me where those are in the record.
A They're actually, I believe, in the jail record notes.
Q Okay. Can you find them for me?
A If you hang on just a moment here.
Q Thank you.
A I know one's on 6-25, and I believe there's one on

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6-20 and 6-21 or '2.
Q And what documents are you looking at?
A The jail -- jail log.
Q The jail log?
A In the jail log, there's one on -- let's see here.
Q Well, that's not the medical records, is it?
A No, but I mean -- I guess all of it is part of the medical record. If there's information listed, that's medical.
Q Well, Doctor, testimony has revealed through one of the nurses -- expert nurses that what you're looking at is the nurse timeline, right?
A I don't know. Is that the --
MR. CHAPMAN: I'm going to object. I'm not sure the -- I don't believe that's what he's looking at. I believe he's looking at another document.
MR. PERAKIS: I don't know either. I -- exactly right. I don't know.
Q If you can tell me what you're looking at, that would be great.
MR. MCQUILLAN: These pages are Bates numbered if you'd like them.
MR. PERAKIS: Okay. Well, what do you have?
MR. CHAPMAN: He's looking at Exhibit 19 from

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Follmann's (phonetic) dep, which is the training log, I believe. He's got mental health logbook 8-17 to 27, 2014.
Q Oh, you're looking at the mental health log; is that right?
MR. CHAPMAN: I believe that's what he's looking at.
Q Is it handwritten, Doctor?
A Yes.
Q Okay. Well, are you aware that that mental health log is not available to the nurses?
A I don't know.
Q Okay. Are you aware that -- so that's the one. Let's say that's the 19th, is what you're looking at; is that right?
A (No response.)
Q Is that yes, Doctor?
A Well, the one on 6-23-14. It says Nurse Dixie in mental health to check David. Inmate up and aware, drinking water.
Q That's on the 23rd. Okay.
A 23rd at 15- --
Q Okay. What other one are you looking at?
A And then on the -- no. Let's see here. On the 25th it says at 2145 hours nurse checked vital

signs on mental health 1, vital signs checked, good.
Q Okay. So I know what you're talking about. And I know that that examination took exactly 30 seconds on June 25th. All right.
A Okay.
Q Now -- so what you're telling me is from June 24th to the day he died, before he died there was a total of one nurse visit that totaled 30 seconds, right?
A I -- I don't know the timing of them. There was a nurse visit office, obviously, on the 23rd and the 25th.
Q Right. But -- well, the 23rd would have been five days before he died.
A And it says he's up and aware and drinking water.
Q On the 23rd?
A Right.
Q Is that right?
A Yes.
Q Okay. And then we -- and then the one you -- the one you mentioned is the 25th?
A Yes.
Q And that's -- as I tell you, it's 30 seconds long. Okay. So is it your -- is it your opinion that

those -- that those -- that process of monitoring was sufficient so as to not be deliberately indifferent?
A Well --
MR. CHAPMAN: I object to the use of the term again.
MR. PERAKIS: I understand. I'm just using his term. I don't know what to tell you, Ron.
MR. CHAPMAN: You're using it intentionally so you can argue to have it excluded later, and that's what bothers me here.
MR. PERAKIS: Well, Ron, Ron, it's his term. I'm not using it for anything other than going through this report. I don't know what to tell you.
MR. CHAPMAN: You're not looking at the report right now. This question has nothing to do with it.
(Attorneys talking over each other.)
MR. PERAKIS: (Indecipherable.)
MR. CHAPMAN: My objection is stated. My objection is stated. We'll make the argument to the Court. You can't set it up and then try to take it away later when he testifies there's no deliberate indifference.

MR. PERAKIS: Fair enough, fair enough.
Q So let me just summarize this part of it at least. So we know that you are giving an opinion on deliberate indifference regarding the medical staff, right? Dr. Stoltz?
A Well, I don't want to make a legal determination here, but I'm saying I do not -- I felt the medical staff did see David. They, you know, documented vital signs, document he's drinking water on the 23rd. Mental health was making rounds on David. You know, it's an unfortunate event David went downhill and passed away.
Q Well, you're right. He went downhill, didn't he? You agree with that, right?
A Well, I think there was men- -- obviously there was mental health issues going on, and I believe the psychiatrist has mentioned catatonia, which it all fits in that category. He basically became socially withdrawn and refused to eat, apparently, and eventually expired probably from electrolyte imbalance. But --
Q Okay.
A -- the medical staff didn't intentionally avoid seeing David. They went by and saw him. Mental health went by and saw him every day. And it -- it

finally got to the point in the end, unfortunately before he died, they felt it's time to get a psychiatrist involved and do other things, but unfortunately he passed away before then.
Q You agree, don't you, Dr. Stoltz, that the symptoms that he was suffering that was causing him to go downhill were consistent with withdrawal from benzodiazepine, right?
A Actually, no, in my opinion, probably not. He had been off benzodiazepines for a considerable amount of time before he came into jail, which we've discussed many times. And my true opinion is Dr. Sherman appropriately, in his best medical judgment, felt he did not need to be on withdrawal protocol for benzodiazepines. He'd already been withdrawn from benzodiazepines.
Q That's not the question I --
A There was no symptoms. His vital signs remained stable throughout, including in the very end. So I don't know how much more I can say. I've told you this three times.
Q Dr. Stoltz, Dr. Stoltz, I didn't ask you that question. I asked you whether the symptoms that David suffered from during what you deemed to be a downhill process were consistent with symptoms

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suffered by someone who's going through benzodiazepine withdrawal?
MR. CHAPMAN: Objection, asked and answered. He already testified to that.
A That's exactly what I --
Q What's the answer?
A I just answered that last statement.
Q You -- well, wait a minute. You -- how did you answer the question? Not what you want to say, how did you answer the question -- I'll make it real simple for you, Dr. Stoltz.
The symptoms that he was suffering from, were those symptoms consistent with benzodiazepine withdrawal?
MR. CHAPMAN: Objection, asked and answered.
Q What's the answer?
A I already answered that.
Q Okay. Then we'll try it a different way, Doctor.
What symptoms was David suffering from during the downhill process that you described?
A Most likely from a mental health disorder that came out because he was off his medications that he first came into jail with. And I would refer that to a psychiatrist or neurologist, you know, for their opinion, but most probably to a psychiatrist

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to explain that more in detail.
MR. PERAKIS: Okay. Well, Madam Court Reporter, could you please reread that? I didn't hear the answer.
COURT REPORTER: Sure.
MR. PERAKIS: And could you go slow so I can write it down?
COURT REPORTER: Yes, sir.
MR. PERAKIS: Thank you. I'm sorry.
COURT REPORTER: No problem.
(The requested material was read back by the court reporter.)
Q Doctor, so are you aware of what the medical examiner said as it relates to causation of death?
A I saw the report.
Q And what was it?
A I don't have the actual wording in front of me, but it was, in essence, some complications of benzodiazepine withdrawal.
Q Did she also mention severe dehydration?
A I'd have to pull the report up.
Q Dr. Stoltz, did any medical health professional -- or excuse me, mental health professional call any psychiatrist to evaluate David from June 18th to his death?

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A Well, that was part of the conference -- care conference on the 26th. And I believe an appointment was set up for the 30th for a psychiatrist to come see him.
Q Okay. So what you're telling me is from June 18th until June 26th there was no referral to a psychiatrist or mental health professional; is that right?
A Well, mental health was seeing him on a daily basis.
Q Well, I'm talking -- you understand that there are higher levels of care, don't you, in the mental health profession?
A Yes.
Q And that if a limited licensed social worker or limited licensed professional doesn't know what's going on, what is the proper protocol for a -- for -- to -- that would provide a higher level of care?
MR. CHAPMAN: Object to form and foundation.
Q Go ahead, Doctor.
A Well, generally, in their judgment, at what time they feel someone else needs to be involved, they'll contact someone higher up the chain of command in the mental health.
Q And that would be such as a psychiatrist, right?

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A Could be.
Q And what about a mental health professional like Natalie Pacitto, the director of mental health? Someone like her?
A Yes, could be.
Q Okay. And up until the 26th, that never happened? Neither Ms. Pacitto nor the psychiatrist on call was ever -- was ever referred to to be seen by -- to see David, right?
A I can't recall when Ms. Pacitto got involved. I'd have to look at the notes.
Q Well, why don't you go ahead and look at your notes because -- just go ahead and look at your notes.
A (Witness complies with request.)
(A discussion was held off the record.)
Q Any luck in finding something about Ms. Pacitto?
A No, I'm still looking.
MR. CHAPMAN: What was the question? I got distracted. What's he looking for?
MR. PERAKIS: I'm sorry about this, Court Reporter. Could you please ask the question again?
COURT REPORTER: No problem.
(The requested material was read back by the court reporter.)
MR. PERAKIS: Thank you.

COURT REPORTER: You're welcome.
Q Any luck yet, Doc?
A No.
Q Do you -- I'll just -- let me ask you this. You know, we've had about ten minutes or so for you to look at the records pertaining to the psychiatrist for Ms. Pacitto, and you haven't been able to find it, right?
MR. CHAPMAN: Wait a second. Wait a second. I strongly object to that. I'd stepped out of the room at 1:59, and you hadn't even asked the question yet, and now it's 2:04. That's less than five minutes.
MR. PERAKIS: Oh, I'm sorry. I'll -- whatever time it was. I wasn't trying to be abusive to the time because it's hard to lie about time.
MR. CHAPMAN: Well, but most people do exaggerate about it, not intentionally, but they do because a minute seems a lot longer than it really is.
MR. PERAKIS: Well, if he needs more time, I'm not worried about it. That wasn't my point.
MR. CHAPMAN: I don't know whether he does or not. I was just commenting on the ten minutes.
Q Dr. Stoltz, do you have any idea how much more time

you think you'll need? I don't want to waste your time or ours.
MR. CHAPMAN: I would only object because how could he know that?
A I've got all day.
Q Fair enough.
Well, Dr. Stoltz, I sure am glad I'm getting that Medicaid rate. I really do appreciate that.
A You're a heck of a guy.
Yeah, I thought I had something in the notes here that said that. I don't see it here, so maybe they did not refer.
Q Okay, okay. So then I'll just ask you this question. Whatever amount of time you had to look at your records, do you see any -- do you see anything in the records before you that demonstrate that any medical or mental health CCS employees referred David to a psychiatrist or Mental Health Director Pacitto before his death?
A Let's see. I think I see something right here I'm looking at. Well, I mean, in the deposition of Chantalle Brock -- I just happened to pull this up -- she did say she recalls speaking with her supervisor, Natalie Pacitto, and also referred him to a psychiatrist either the -- apparently on the

27th.
Q Yeah, the 27th was when she -- she just finally decided to refer him to a psychiatrist, right?
A From the note.
MR. CHAPMAN: Objection to the word "finally." Pejorative.
Q Okay. So -- well, Doctor, I'm going to -- I'm going to direct you to looking at -- so, Dr. Stoltz, let me just conclude with this part of it. Up until the date David died, which is June 27th, did any mental health professional of any type employed by CCS refer David for an examination by a psychiatrist or by the higher level mental healthcare -- mental healthcare professional Natalie Pacitto?
A Well, according to the deposition not until the 27th.
Q Okay. So -- and that's Chantalle Brock's deposition, right?
A Right.
Q Well, you know, just so you have an appreciation for this, if you look at Chantalle Brock's examination of -- the self-harm watch mental health observation follow-up note that is dated June 27th, if you have it --

Any luck, Dr. Stoltz?
A Still thumbing through the pages here. What's the question?
Q I'm sorry. Well, the question is, is on -- on -- you have to take a look at the document. On that document, is there anywhere in there that suggests that Chantalle Brock has decided on June 27th, six hours before David dies -- or, no, seven hours, I'm sorry, that she's decided to refer him to a psychiatrist or -- or Pacitto?
A Not that I see on this page, no.
Q Okay. And on that page once again -- and I'll try to avoid going through all of them, but you have all the self-harm watch mental health observation follow-up notes from the mental health people because you feel that that was somehow a sufficient monitor. Do you have the notes or those follow-up notes from June 19th to June 26th --
A Yes.
Q -- 27th? I'm sorry. You do?
A Yes.
Q All right. So let's look at the June 27th one just real quickly. And you agree, don't you, that in the mental health status report on that particular day, every -- every observation has with it unable

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to assess, patient refused except for the appearance part, right?
A Yes.
Q All right. Do you have any evidence that suggests that the last one when it comes to cognitive estimate is checked as average, why any mental health person at this point would check average as the cognitive estimate?
A I don't know. Maybe he responded. I don't know.
Q You don't know? It doesn't show that he responded anywhere, right?
A No.
Q Every one of those says unable to assess, patient refused, right?
A (No response.)
Q I'm sorry. Did you answer, Doc? I didn't know if I heard you.
A Repeat. What was your question?
Q Yes. You agree, don't you, on the mental status assessment, every one of the observations say exactly the same thing, unable to assess, patient refused, the block -- the box "other" checked except for the one about appearance, right? And that's -- you said correct?
A Except appearance? You mean -- you mean

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subcognitive --
Q It's about the -- no, it's about the seventh one down on mental status. There's sensorium, behavior, food --
A Oh, yeah. Yes.
Q -- thought process. Do you see that?
A Yes.
Q And all -- all -- and what she says is patient was observed lying on floor, naked in cell, under bunk bed with eye fluttering movements.
A Yes.
Q Do you see that?
A Yes.
Q Is a psychiatric evaluation or referral supposed to be immediate, or are we supposed to wait over a weekend for it?
MR. CHAPMAN: Object to form and foundation.
Q If you know.
A Well, you can put a referral in immediately, but at the time someone sees them, psychiatrist or higher-level person, depends on when they're available many times.
Q Right. And you agree, don't you, Doctor, that on this particular document there is zero indication that she has requested a referral to the

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psychiatrist or Ms. Pacitto, right?
A Well, it's not on this document, but from my understanding and information, there was a care conference the day before to get a psychiatrist referral set up.
Q I understand that. But you agree, don't you, that the day after and even the day of the alleged care team meeting -- or the care team meeting, the -- the people who are seeing David do not make that recommendation, right?
A I don't know if they already knew about the recommendation or not.
Q Well, wouldn't be it pertinent to put it in your record if it was -- if they did?
A It would be ideal.
Q Well, but it would also be pertinent, not just ideal, right?
A Well, if you already knew it was going to happen, you may not put it in the record. You may not put it in yourself.
Q Okay. So if we go to the day before, June 26th, Ms. Nelson also has almost an identical form that she's filled out; do you agree? Now I'm talking about in comparison to Ms. Brock. Do you see that?
A Very -- very similar.

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Q Very similar. In fact, the only dissimilarity on the first page is that she explains, in terms of her view, the patient was playing on -- was playing [as said] on floor cell -- floor in cell with eye fluttering movement. Do you see that?
A Yes.
Q Okay. So what about page two of both reports on the 27th and 27th? Do you see that?
A Yes.
Q Yes? Okay. And you see that the -- it says review status of factors that lead to placement or watch observation. And you see that those are almost identical also, right?
A Very similar.
Q Okay. And -- okay. So will you agree with me that as to the remainder of the self-harm watch notes, by Ms. Mann on June 25th, by Ms. Brock on June 24th, by Ms. Nelson on June 23rd, by Ms. Brock on June 22nd, by Ms. Brock on June 21st, by Nelson on June 20th and by Nelson on June 19th, you agree, don't you, that none of those medical -- mental health professionals were able to assess David's mental health status?
A Well, I guess I -- I agree, and also I would comment that on the 23rd and 24th they make in

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their note mental health status, expects patient is exaggerating symptoms for secondary gain. He's not acted out self-injuriously within the facility.
Q Okay. Well, do you have any idea how that came about, that all of a sudden he's exaggerating his symptoms?
A Well, he was seen in medical twice.
MR. CHAPMAN: Objection to "all of a sudden." Did you get my objection? Form and foundation.
COURT REPORTER: Would you --
MR. PERAKIS: I got it. I got it.
MR. CHAPMAN: Objection to the form of the question. You might have it. I want to make sure the court reporter did.
COURT REPORTER: Would you repeat your objection, please?
(No response.)
Q Dr. Stoltz, do you under- -- do you know the underlying facts that would cause these people to not put exaggerating symptoms for secondary gain in any of the other assessments?
A Well, I would -- you know, obviously, I'd be guessing, but I would guess that the mental health people look at the notes from the day before. They've already talked about David. They're -- the

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whole team is probably aware of David. That's usually what happens. And they're just going by daily and evaluating him, and they feel the same way. I mean, he'd been to medical twice with thoughts of faking symptoms, so to speak. But also mental health would even -- they did not give him medications. He all of a sudden withdrew. So I'm sure that's what their thought process was at the time.
Q Well, you know, I was just -- I was just -- are you done? I'm sorry.
A Yeah.
Q Okay. Well, I was just scolded by Mr. Chapman to not use "all of a sudden," and then you just used it. So are you telling me that you believe the records indicate that all of a sudden he wasn't cooperating?
A I don't see where it's all of a sudden. It started awhile back when he --
Q Yeah. The fact is this claimed lack of cooperation had been identified variously by the mental health people as either unresponsive or refusing to answer. You agree, right?
A Well, he -- he answered initially until they wouldn't give him medication, and then he would not

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cooperate. And, you know, then when he came to medical, he was --
Q All right. So --
A He came down in a wheelchair. And the next thing you know, he walks out of medical and walks back fine.
Q Well, how many days was that before he died, Doctor?
A It was -- I -- approximately a week to ten days before.
Q Okay. So are you telling me that the -- that the staff all just decided he's exaggerating? He's more than capable -- he's more than capable to do what is necessary, but he's only doing it because he's a drug seeker; is that what your testimony is?
A That, I don't -- I did not say that, but I don't know that's the case.
MR. CHAPMAN: Object to form.
A I think the -- the medical staff and the mental health staff obviously felt he was pulling their chain a little bit. And then there was a note from the nurse when she came in that he drank water. He talked to her. Vital signs were stable multiple -- you know, several times that we talked about. You know, it was just an unfortunate event David

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eventually passed away.
Q Well, but let me ask -- let me ask you this, Doctor. You said he eventually passed away. Are you telling me that there was no chance or opportunity for anybody to save his life during the last ten days of his life? Is that your testimony?
A Well, my testimony and my expert opinion would be that --
MR. CHAPMAN: Object to form and found- -- wait, wait, wait. Object to form and foundation, calls for speculation.
MS. SWINDLEHURST: I'll join.
Q Okay. What's your testimony?
A Well, I agree it calls for speculation. But in my opinion, he was seen by medical, he was seen by mental health. They felt he was medically stable, although mentally unstable and uncooperative. And they finally, you know, at the point later got a psychiatrist consulted. You know, I think they had -- they were surprised when the events ended as they did.
Q Well, the psychiatrist never consulted with anybody, did he?
A He was called to consult and never -- he did not get there before he passed away.

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Q Well, where in the records does he say he was called to consult?
A Well, it said on the 27th.
MR. CHAPMAN: Object to form and foundation. That's the -- never mind.
Q Okay. What was that?
A On the 27th from the deposition --
Q Doctor, what was that?
MR. CHAPMAN: I think he's saying on the 26th.
MR. PERAKIS: Oh, okay.
Q But I think what you were talking about was that Chantalle Brock had called for a referral to the psychiatrist on the day he died, right?
A Well, the care team meeting, plus she mentioned that on the 27th, right, in her deposition.
Q Doctor, do you have the care team meeting notes with you?
A Not in front of me, no.
Q Can you get them, or shall we e-mail them over to you? What do you think?
A You can e-mail them.
Q It will only take a minute.
A You can e-mail them?
Q What's that?
A E-mail is fine.

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Q I'll do that right now. Okay?
A Okay.
Q I will take two minutes.
(A discussion was held off the record, a 30-minute lunch recess was taken, and Mr. Perakis disconnects from the Polycom.)
MR. IHRIE: The next phase I'm going to be doing the questioning now.
EXAMINATION
QUESTIONS BY MR. IHRIE
Q Doctor, in your report I would ask you to look at page four. I'm sorry, that's page five. Look at page five. The last paragraph in the middle, I would draw your attention to the last line of that paragraph which says "then according to notes and video..." I thought you indicated before that you didn't look at video. Is that true or not true?
A No. Actually, I got that out of the deposition -- one of the depositions from the mental health --
Q Well, why would you say then that according to notes and video became progressively more withdrawn? Why wouldn't you say according to notes and the report of X or Y or C?
A Well, I probably should have done that.
Q Why didn't you?

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A That's just the way I wrote the report.
Q That's inaccurate then?
A Well, it could have been written differently. It's just a matter of semantics.
Q Just for clarification purposes, you testified that when Dr. Sherman saw David on the 17th that he suspected that David was faking his seizure symptoms; is that correct?
A Yes.
Q Is that correct?
A Yes.
Q I didn't hear your answer, sir.
A "Yes."
Q Have you ever had an occasion to look at the cover article of "Correct Care Solutions" magazine dated the fall of 2017 entitled "Patient Malingering"?
A I may have. I don't recall offhand if I've seen that or not.
Q I'm just going to read you one paragraph from it, and I'm going to ask you if you agree with the paragraph or not. The paragraph says even advanced providers need to be very cautious about deciding that a patient is malingering. One correctional physician, Scott Savage, D.O., asserted that malingering must always be considered a diagnosis

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of exclusion. Literally every other possible cause of the patient's symptoms must be ruled out before deciding if the patient is malingering. Do you agree with that statement?
A Yes.
MR. CHAPMAN: I would object to form and foundation --
Q Thank you.
MR. CHAPMAN: -- and use of the word malingering. Let me finish before you jump in. I know you're angry, and we can -- we know this from your voice. But calm down and let me state my objection on the record, please.
Q Now that you've indicated, Doctor, that you agree with that statement, tell me what other -- what other diagnoses that Dr. Sherman ruled out after the 17th?
A Well, I can't speak for Dr. Sherman, but --
MR. CHAPMAN: Wait, wait, wait, wait, wait. I'm going to -- I'm going to object to this line of questioning. You can't switch attorneys in the middle of questioning and have that attorney go back over things that were already discussed. That's inappropriate.
MR. IHRIE: Well, this was -- this was not

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already discussed, but...
MR. CHAPMAN: Do you have a court rule that allows you to do that?
MR. IHRIE: All right. Your objection is noted. Your objection is noted.
Q So is there anything in the medical record that indicates that Dr. Sherman ruled out any other, quote, possible cause of the patient's symptoms, unquote?
A Well, as I was going to say, I can't speak for Dr. Sherman. But typically a physician, when you would evaluate someone, you may not write every potential differential diagnosis down on a list or piece of paper and progress note, but you think in your mind could this be this or that or whatever else, and, you know, then you come up with your conclusion I feel the patient is faking or feigning the seizures.
Q Well, I'm not asking you to decipher Dr. Sherman. My question is very specific. Is there anything in the medical record that indicates that Dr. Sherman took any steps of any kind to rule out, quote, other possible causes of the patient's symptoms, unquote?
A Well, he medically evaluated him, and that was his

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conclusion in the impression and his plan.
Q I understand that he evaluated him and that his conclusion was that he was feigning and, to your use word, faking. My question is did he do anything to rule out other causes of the symptoms? Can you see anything in the medical record that he did so?
A Well, I -- I don't think you may necessarily see that in any medical record unless -- it depends on what the complaints are. When the guy comes in and he's blinking his eyes and you talk to him and he stops or if he comes in in a wheelchair and the next thing he's walking up and he's perfectly fine, it's pretty obvious that there's nothing significant going on at that moment in time.
Q And that is -- and that's what Dr. Sherman concluded, right, that he was faking?
A Yes.
Q In the article that I just told you, the paragraph --
MR. CHAPMAN: Mr. Ihrie, wait. If you could excuse me for a second. I'm going to make a continuing objection to all of your questioning. There is case law that says only one attorney per one side can begin and end the questioning of a

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witness. I'm objecting to all of your questions. It's inappropriate and it's against the current way things are done in the Sixth Circuit.
MR. IHRIE: Can you cite that -- can you cite that case for me so we can take a break and look it up?
MR. CHAPMAN: Well, right now I'm looking at a case from the American Bar Association, Best Practices for Taking a Deposition. I've only had a second to do this. I'm looking at multiple statements that are here. Do your own search.
MR. IHRIE: Is there a court rule that --
MR. CHAPMAN: I don't have the case right now, but --
(Attorneys talking over each other.)
MR. IHRIE: Is there a court rule that you want to refer me to?
COURT REPORTER: Guys, I'm not hearing you when you're talking over each other.
(Attorneys continue to talk over each other.)
MR. CHAPMAN: (Indecipherable.)
MR. IHRIE: Is there a court ruling --
MR. CHAPMAN: When you're all done, I'll talk.
MR. IHRIE: All right. One moment, please. I'm asking you to consent, Ron, and all attorneys,

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to me making -- answering [as said] questions because Harold has other responsibilities that he has to get to right now. But if you want me to get him back in here, I will, and it's going to be a much slower deposition then. Will you consent to my asking questions?
MR. CHAPMAN: I don't care about that. I think it's inappropriate to be switching attorneys. I don't have a case for you right now. But I just did a quick Google search and looked at the American Bar Association. And everything says best practice is judges do not enforce it. I know in court you would not be allowed to switch attorneys midstream because you're going over things he already has, and that's problematic to me. Whatever you have to do, I'd suggest you probably do it, but my objection stands.
MR. GAZALL: Also, for the record, the County does not consent.
MR. IHRIE: All right. One moment. All right. Your objection is noted. I'm going to continue.
So what was the last question that I had asked, Court Reporter, please? Thank you.
COURT REPORTER: Just a moment.

(The requested material was read back by the court reporter.)

MS. SWINDLEHURST: And I would like to join in that objection as well.

MR. IHRIE: All right. So noted.

Q Doctor, my question remains. Is there any indication in the medical record that Dr. Sherman took any steps to rule in or rule out his suspicion that David was faking his seizures?

MR. CHAPMAN: Objection, asked and answered several hours ago. This is completely inappropriate.

Q What is your answer, Doctor?

A The only thing I could say is what's in his progress note is what is there.

Q Well, I understand. We all know what's in his progress note. That's not my question. My question is, is there anything in the medical record that indicates that he took any steps to rule in or rule out the legitimacy of his suspicion that David was faking?

A He did not specifically write down a differential diagnosis list. His comment was as I had mentioned previously.

Q Thank you. Now, are you aware -- or strike that.

Have you read Dr. Sherman's deposition?

A Yes.

Q Are you aware that Dr. Sherman said that David never told him that he had a seizure?

A I'd have to look at his deposition to verify that.

Q All right. Are you -- are you aware that the -- that Dr. Sherman's deposition -- in his deposition he listed all of the symptoms of seizures, none of which David presented with? Are you aware of that?

A I'd have to look at it directly just to verify what you're referring to.

Q All right. Let me do my best to locate that particular portion of his deposition for you.

A Okay.

Q Doctor, I'm going to refer you to Sherman's dep, page 137. Tell me when you get there.

A Okay. Just a minute.

Q All right. Do you see on page 137 starting at line 7 -- I will read it. Question -- this is to Dr. Sherman when he's talking about David being down in the -- in the medical cell on the 17th, allegedly. Your seeing him -- Question, "Your seeing him several hours later would have given him plenty of time to become responsive again, correct"? Answer, "That's correct." "Did he tell

you he had a seizure?" "No." "Did he ask for something because he had a seizure?" "No." "Did he tell you that because my eyes are fluttering that must be an indication, Doctor, that I'm having a seizure?" "No, he didn't say that." "Did he use the word seizure at all?" "No." "Did you think or suspect that by fluttering his eyes he was trying to mimic a seizure?" Answer, "Yes." "Why did you think that?" "Because this was the behavior that he had going on that whole day." "How do you know?" "The nurses told me."

So does it sound to you like at that point, Doctor, that David ever told Dr. Sherman that he was having a seizure?

A Oh, I don't think he told him he was having a seizure, no.

Q Well, who told the doctor, if you know, that he was having a seizure or seizure-like activities?

A Well, I think because he was doing the eye movements, and I believe -- let me see back here (indicating).

Q Well, you would conclude, would you not, that he was doing -- he had eye movement and eye fluttering and rapid eye movement throughout his entire ten-day stay up in the -- up in the mental health

cell, correct?

A I don't recall if he had it every -- all the time.

Q Well, virtually every mental health professional identified -- at least nine out of ten did, that -- nine out of ten days -- that he had eye fluttering or rapid eye movement or rapid blinking, correct?

A Right. Until actually, I guess -- I was looking at Michelle Bailey's -- or Bey-Shelley's note on the 16th. Patient's eyes twitching ceased when physician assessed him and spoke with the patient.

Q Oh, I understand that's on the 17th. But others reported rapid eye movement or eye fluttering or eye twitching until virtually the day he died, every day; am I correct? If you don't know, I'll draw your attention to each of the -- let's start with the 16th --

A Well, yeah, but I --

Q -- 18th, rather.

A I mean, that's possible that she was -- we know that Bey-Shelley was originally called to his cell because of questionable seizure-like activity.

Q Was rapid eye movement identified by the mental health professional on the 18th?

A I would have to pull that note up.

Q All right.

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A You're jumping all over the place here on me. I see it on the 19th.
Q Well, I know it's on the 19th. If you look at the 18th --
A Yeah. I do see it on the 18th. I do, yes.
Q Okay. You see that he was identified as having rapid eye movement on the 18th, correct?
A Correct.
Q And rapid eye movement -- rapid eye movement on the 19th, correct?
A Yes.
Q And rapid eye movement on the 21st? Can you look at the 21st, please?
A Yeah. I don't see it on the 20th, so it must have gone away on the 20th.
Q I said 21st.
A Oh, I was just making that comment. But, yeah, I see that on the 21st, yes. I do not see it on the 22nd. So apparently it was an intermittent thing, so it's not -- it was not every day.
Q I didn't say every day. I said almost every day.
A It wasn't on the 23rd. It wasn't on the 24th, I don't believe. Not noted on the 24th, not noted on the 25th. So I would say not quite -- less than half the days.

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Q Please look at the 26th.
A (Witness complies with request.)
Q Do you see where it identifies eye flutter?
A Yes.
Q And do you see it on the 27th?
A Yes.
Q Eight hours before he died, do you see it on that day also?
A Yes.
Q So just as an expert, do you think he was faking all those days?
A I would assume he probably had an underlying mental health disorder which contributed to that.
Q Is that a yes or -- I'm sorry? Is that a yes or a no that he was faking -- you think he was faking all those days?
A That, I don't know.
Q What could be done to rule that in or rule that out? What kind of testing could be done?
A Well, he could have a neurologist and a psychiatrist both involved in evaluating him.
Q And that never happened, did it?
A No.
Q And I'll also ask you look at your report on page four, second full paragraph.

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A (Witness complies with request.) Okay.
Q I want to ask you to take a look at the second to the last sentence which reads, quote, "He also noted" -- talking about Dr. Sherman. "He also noted that he did not feel that tapering David off benzodiazepines was necessary after he had been in jail for 6 or 7 days, since he did not show signs of withdrawal." Do you see that statement?
A Yes.
Q In point of fact, he was showing symptoms that were consistent with benzodiazepine withdrawal on the sixth and seventh day, wasn't he?
MR. CHAPMAN: Object to form and foundation.
MR. IHRIE: Objection noted.
Q Go ahead and answer, Doctor.
A Well, those could be symptoms from things other than withdrawal.
Q Now, please answer my question. On the sixth and seventh day, he was showing symptoms that were consistent with benzodiazepine withdrawal; am I correct?
A He had some symptoms that could be potentially associated with withdrawal, although he had no vital sign changes of significance. And interestingly, his symptoms he had on those two

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days, those symptoms resolved. He didn't show further symptoms after that point.
Q That what? You mean on the 18th he wasn't having --
A On the 17th --
Q I'm sorry. I'm not sure if I'm hearing my own echo on this, but I'll repeat that again.
Are you saying that because on the 18th there's no notation of hallucinations that the hallucinations that he had on the 17th could be disregarded?
A Well, on the 17th and 18th he had -- there was some notation of potential symptoms of hallucination, and then after that point they resolved.
Q No, they -- I will ask if I can properly correct you. They didn't say that he had symptoms of hallucination. They said he had hallucinations, correct?
A Signs of that, yes.
Q And are you saying that because, let's say, on the 19th he wasn't having hallucinations that it was appropriate for the medical personnel to disregard the fact that he had had them on the 17th and/or 18th?
A I'm saying if he had those and they were withdrawal

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symptoms, they would have most likely got progressively worse.
Q Did David experience any withdrawal symptoms from benzodiazepines from the point he got in the jail until he died?
A Not that I can be sure of.
Q Oh, I didn't ask you to be sure of them. Can you -- just can -- or do you see any symptoms that he had that were consistent with benzo withdrawal?
A He had some symptoms that if you look at the symptomatology with withdrawal, that could -- yes, it could be part of the same symptomology. Although the same symptomatology goes with other mental health disorders as well.
Q And what did Dr. Sherman do or a nurse do or anybody do to rule -- to determine which it was, benzodiazepine withdrawal symptoms or symptoms from somebody else -- something else, rather?
A Well, Dr. Sherman did not feel it was from withdrawal. And eventually they had their team meeting on the 26th, including a psychiatrist, and they referred him for a psychiatric evaluation.
Q I didn't ask what Dr. Sherman felt. I asked what was done by Dr. Sherman or any other medical personnel to rule in or rule out benzodiazepine

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withdrawal.
A They monitored the patient.
Q I understand that he was monitored. I'm not asking -- I'm not asking whether or not he was monitored. We fully acknowledge that he was thoroughly monitored. My question isn't about monitoring. My question is about what treatment did he receive to rule in or rule out whether the symptoms were caused by benzodiazepine withdrawal or by something else.
A Well, he had mental health -- put in a mental health unit and mental health evaluation and follow him.
Q And mental health monitored him, correct?
A Correct.
Q And what treatment did mental health give to him --
A Well, mental health --
Q -- other than monitoring him?
A Medical came by and saw him and checked vital signs and checked on him, and mental health went by daily. And at one point initially when he refused -- or they did not give him medications he wanted, he became withdrawn and would not interact with them much at all since.
Q I understand that they monitored all that. My

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question is what treatment did he receive for either benzodiazepine withdrawal, if that was the cause of his symptom, or whatever was the cause of his symptoms?
A Well --
Q What treatment did he receive?
A He had no treatment for benzodiazepine withdrawal because they did not feel he had that. But he was actually going to see a psychiatrist, but unfortunately he passed away before.
Q What did he re- --
MR. CHAPMAN: Please don't interrupt him.
MR. IHRIE: I didn't interrupt him.
Q What did he receive treatment for?
A He did not receive treatment for anything.
Q Thank you.
A He had no definitive diagnosis.
Q Nobody diagnosed him?
A He had no --
Q So your testimony is A -- your testimony is, A, nobody diagnosed him and, B, nobody treated him for anything; is that correct?
A He had no definitive diagnosis. He was to see a psychiatrist, and it's possible he had catatonia, which is -- would be compatible with his condition.

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Q Well, possibly, I suppose.
A There's a lot of hypothetical things to consider.
Q Nobody --
MR. CHAPMAN: You guys are talking over each other. I wish you would slow down, Mr. Ihrie. I know you're upset, but try to slow down and let him answer.
MR. IHRIE: My name is pronounced Ihrie.
MR. CHAPMAN: Mr. Ihrie then, I wish you would slow down. I know you're upset, but you can't talk over the witness.
MR. IHRIE: I'm not upset at all, Ron. I'm not upset at all.
MR. CHAPMAN: Then why are you screaming?
MR. IHRIE: Well, maybe I'm speaking a little loud because it's so hard for me to hear. I'm thinking that maybe it's hard for you guys to hear too, so...
MR. CHAPMAN: No. We can hear you fine.
MR. IHRIE: All right. Thank you.
Q I'm going to draw your attention now to the care team meeting note on the 26th, Doctor.
A Yes.
Q What is a care team meeting, if you know?
MR. CHAPMAN: I'm sorry. What was the

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question? Where is it or what is it?
Q The question was what is a care team meeting, if you know?
A Well, typically different jails will have care team meetings to discuss particular patient issues and get different parties involved to develop a plan of attack, so to speak, on what needs to be done further for a patient.
Q So at a care team meeting, is every patient that is under medical or mental healthcare -- is every case reviewed, you know, dozens or --
A No.
Q -- scores or hundreds of them?
A No. There tend to be select --
Q No?
A The select top -- or more complicated cases.
MR. CHAPMAN: You need to let him answer. You can't interject. Please. Go ahead.
MR. IHRIE: I didn't say anything, Ron. I didn't say anything.
MR. CHAPMAN: You did.
Q I'm sorry, Doctor. Go ahead.
A There tends to be select, more complicated cases where you get different parties together that could have input on how to evaluate someone further.

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Q So David's case would have been one of the more complicated ones?
A Most likely.
Q And what would make David's case more complicated?
A Well, as you mentioned previously, he was failing to respond to mental health people. He had what was thought to be fake seizures. He was -- would come down to medical in a wheelchair, could not walk away -- or walked away just fine after his evaluation. So he -- there was -- obviously he was brought to evaluate him further from a mental health standpoint.
Q And could we add into that list the fact that he had had hallucination?
A Could be.
Q And eye fluttering?
A Could be.
Q And rapid eye movement?
A Could be.
Q And shaking?
A Could be.
Q And nonresponsiveness or either unwilling or unable to speak, those things?
A If it was my care team meeting, I hope that every symptom and every issue was brought to the table to

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discuss further about the patient.
Q So was that a yes to my question?
A I thought I just answered your question.
Q All right. So was Dr. Sherman at the care team meeting?
A From the attendees list, yes.
Q Does that mean that when you're at -- when Dr. Sherman was there, that he either had -- that he either gave input or had the opportunity to?
A That's generally why you're there.
Q And do you see at the bottom of page -- the second page, do you see at the bottom where it says Natalie pass --
A Yes.
Q -- under -- do you see that? So Natalie Pacitto, the director of mental health, she passed. Does that indicate to you she had nothing to say?
A I don't know.
Q Monica Cueny, the director of nursing, do you see where she passed?
A Yes.
Q Does that indicate that -- would you conclude from that that she didn't have anything to say either?
A Well, I -- I don't know. I mean, it's possibly at these meetings Dr. Sherman is the one that brought

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David to the attention, and he was going to be the one to discuss it. I don't know how that works at their actual meeting.
Q Now -- I suppose anything is possible. I'm just looking at what the document says. Dr. Haque was the psychiatrist. Does it appear that he passed as well?
A I don't know. That's what it says, pass.
Q Well, it says pass, doesn't it?
A It says passed.
Q Then we get to Dr. Sherman. Do you see where it says seen in clinic on 6-24?
A Yes.
MR. CHAPMAN: I'm going to object to the line of questioning.
Q And was --
MR. CHAPMAN: He didn't -- wait a second. I object to the questioning. He didn't draft the document. The document and the author speak for the document, not this witness.
MR. IHRIE: Well, I'm asking this witness about this document.
Q Do you see where it says that the -- David was seen in the clinic on June 24th?
A It says that.

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Q Pardon me?
A It does say that.
Q Was that true?
A I can't remember if he got brought down to the clinic on the 24th or not for an evaluation. I'd have to look back.
Q So do you see where it says next that Dr. Sherman symptoms says not concerned?
MR. CHAPMAN: Object to form and foundation. No foundation Dr. Sherman said that.
A I see it says that.
Q Who would you conclude that's saying they're not concerned, Doctor, after looking at this document?
A Well, just if I would just look at the document, I would think from a medical standpoint he was not medically concerned. He was --
Q Who was not medically concerned?
A Dr. Sherman did not feel he had medical concerns. His vital signs were normal, and he didn't feel he was medically concerned, but mental health staff had issues going on with him.
Q And then it next says that mental health staff indicates he is refusing or unable to engage in visits with them. Do you see that?
A Yes.

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Q What is the difference between somebody refusing or somebody being unable to engage?
A Well, they -- they did not know.
Q No. What is -- I'm asking you the difference between refusing to be engaged or being unable to. Is there a difference between the two?
A Sure. He can refuse -- he can -- I could sit and refuse to answer your questions right now. If I had a stroke and I couldn't speak --
Q That's right.
A -- I'm unable to answer your questions.
Q Thank you. There is a difference between the two, isn't there?
A Yes.
Q And it says mental health staff is also suspecting that he may be med seeking, correct?
A Correct.
Q And can you tell me, up until the 26th, did the mental health staff or -- which would include Pacitto or the psychiatrist, did they do anything to rule in or rule out whether or not he was simply -- his conduct was simply an effort to be seeking meds?
A Well, I believe that the time that -- and I don't remember the visit date now offhand, when he was

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asking for medication and then they said no, he withdrew at that point.
Q I understand that. But this note doesn't say that the mental health staff has concluded, does it? It says that mental health staff has suspected. Isn't that what it says?
A Well, and then also it says but to rule out any possible mental health condition, he will be seen by a psychiatrist on Monday. So they felt he needed --
Q Now answer --
A -- to be seen by a psychiatrist.
Q Are you finished?
A Yes.
Q Are you finished? Okay. Now answer my question. It doesn't say that the mental health staff has concluded; it says that they're suspecting that he may be med seeking, correct?
A Correct.
Q What did they do to rule in or rule out their suspicion?
A They have set up a psychiatrist visit for him.
Q In fact, the note specifically says to rule out any possible new condition, he will be seen by a psychiatrist on Monday, correct?

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A Correct.
Q Now Dr. Sherman understands -- or would understand, in your opinion, would he not, that David is being reviewed because it's a complex case, that he is -- he may be unable to communicate and that -- at least those two things, correct?
A That's speculation, but I would hope he -- he was at the point something needed to be done further to evaluate what's going on with him.
Q And so could he have gone to see David that day?
A Well, Dr. Haque was at the -- the psychiatrist, was at the meeting. And if he felt that it was an urgent issue, I would have hoped he would have gone to see him that day.
Q I'm talking about Dr. Sherman. Could Dr. Sherman have gone to see him that day?
A Well, he could have, but I think it's -- it was more of a psychiatric issue, they felt, than a medical issue.
Q Well, with somebody potentially unable to engage, that could be either a psychiatric or it could be something physical, correct?
A It could be, but he was displaying symptoms of a psychiatric issue.
Q And Dr. Haque was actually at this meeting,

correct?
A That's correct.
Q Could Dr. Haque, when he left the meeting, maybe take a little walk down the hallway and up an elevator floor to go see this complex case named David Stojcevski?
A Well, I would presume, how it was discussed and presented at the meeting, if he felt that it was an urgent condition or an urgent issue, he would have seen him that day.
Q My question is, could he have gone to see him that day?
A Well, sure.
Q But he didn't, did he?
A No.
Q And Dr. Sherman didn't go see him that day either, did he?
A No.
Q And Nurse Cueny who was there didn't go see him either that day to follow up, did she?
A Not that I am aware of.
Q And Natalie Pacitto didn't go see him either that day, did she?
A Not that I'm aware of.
Q And he died the next day, didn't he?

A He did.
Q One moment, please. All right. Doctor, does it appear to you from looking at these care team notes that Dr. Sherman, on the day of this care team meeting, felt that David was faking seizures?
A That's what the note says.
Q And how would Dr. Sherman know that he was faking seizures if he hadn't even seen him for ten days?
MR. CHAPMAN: Wait a second. You didn't understand his answer, sir, or you're intentionally mischaracterizing your question.
MR. IHRIE: Ron, may I make a request of you? Would you quit accusing me of intentionally asking questions that are -- that are wrong or -- I'm not intentionally doing any of those things. All right?
(Attorneys talking over each other.)
MR. CHAPMAN: (Indecipherable) and your question is incorrect. So you either do it accidentally or intentionally. I don't know what it means. What was the question then?
MR. IHRIE: All right. What was the answer to his question that I didn't understand correctly?
MR. CHAPMAN: He said no, and your question came back that how could -- how could Dr. Sherman

know that he was faking seizures. You should have listened to his answer.
MR. IHRIE: Well, maybe I didn't hear him correctly, so I'll ask the question again.
Q How was it that Dr. Sherman knew he was faking seizures on the 26th when he hadn't seen him for ten days -- or not ten days, when he hadn't seen him for -- hadn't seen him for nine days?
MR. CHAPMAN: I'm going to object to the form of your question. You didn't hear his answer to the previous question. You should go back and listen do it.
MR. IHRIE: His said -- his answer to the previous question was that's what the note says.
MR. CHAPMAN: I don't believe so.
MR. IHRIE: Yes, that is exactly what it was.
Q So my next follow-up question is, how could Dr. Sherman say on the 26th that he was faking seizures when he hasn't seen him for nine days, Doctor?
A Well, I'll clarify things. That's not what I said. What I said -- you asked me if the care note said -- did it say in the care note Dr. Sherman feels he is faking seizures. Yes, that's exactly what it says there. It does not -- it doesn't say anything

about on June 26th. Dr. Sherman saw him on 6-17 after he was referred down there from one of the nurses for possible faking seizures. After his evaluation he felt was faking seizures and sent him back to general population.
Q Well, let me ask -- let me ask it differently.
This care meeting is happening on the 26th of June, correct?
A Yes.
Q And Dr. Sherman is present, correct?
A Yes.
Q And the note says Dr. Sherman feels. Is the word feels past tense or present tense, Doctor?
A To me, the note essentially is kind of giving the history of what's going on with this gentleman, with David. It doesn't say what specific day he felt he was doing this or doing that. It was -- that's part of the history of telling the care team what's going on with this guy.
Q Is the word "feel" past tense or present tense?
A It could be used either way.
Q Please use the word "feel" in a sentence that is past tense.
A Well, when you're speaking from medical and someone's writing -- and I don't see -- I'm going

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to say I felt, but if someone says he feels that he's faking seizure, that could be yesterday. It could be a month ago. It could have been a year ago. It doesn't mean necessarily today.
Q So what you're testifying is that the word "feels" -- and if you go two words later, it says "is" -- "is" is present tense, not past tense, right?
A Well, who knows who's typing up this message in the notes.
Q I don't know who's typing it up. Just answer my question, please. Is the word "is" past tense or present tense?
A Well, it says mental health indicates he is refusing or unable to engage -- that, to me, would be more present tense or at least recently, recent tense.
Q So your testimony is that you don't know what day he was talking about, whether it was that day, the day before, or the 17th? It could be present tense. It could be past tense. You just don't know; is that your testimony?
A My testimony is the only thing in the medical record where Dr. Sherman mentioned that he's possibly faking seizures was on the 17th.
Q Well, what about this note?

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A I don't know who typed the note, what words they're using. I'm just telling you what's in the medical record.
Q All right. Good enough. One moment.
Dr. Sherman's phrase "not concerned," is that past tense or present tense?
A There's not enough information there for me to tell you.
Q So is he saying -- in this note, is he saying he wasn't concerned on the 17th, or is he saying on the 26th he's not concerned?
A I don't know.
MR. CHAPMAN: I'm going to object to form and founda- -- wait. I'm going to object to form and foundation.
MR. IHRIE: So noted.
Q What's the answer to my question, Doctor?
A This is such a brief summary note that I -- I could not tell you for sure.
Q So it may mean that he's not concerned on the 26th, correct?
A I don't know.
Q Well, if you don't know, then my statement is correct. It may be or it may not be, correct?
A Well, it's possible.

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MR. CHAPMAN: Object to form and foundation. You're being argumentative. He already answered the question.
MR. IHRIE: I'm not being argumentative, but I want an answer to the question.
Q If you don't know, that means that it could -- it could be today, the 26th, or it could be a previous day, correct?
A There could have been a longer discussion at this meeting and someone's just abbreviating the answers. I don't know.
Q Now answer my question. The day that he says he's not concerned could be the 26th or some previous day, correct?
A Could be.
MR. CHAPMAN: Objection, asked and answered.
MR. IHRIE: I want an answer to my question. It has not been answered.
Q What day was he not concerned, Doctor?
A I've answered it four times, I think. I don't know.
Q Thank you. Please look at the last page of the note. Do you see it?
A Yes.
Q Do you see where it says no prior mental health

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history, never housed in MH?
A Yes.
Q When this says no prior mental health history, didn't Nurse Cueny indicate in her note that he had been psychiatrically hospitalized for anxiety?
A Yes.
Q So is this note in the nursing -- in the care team note, is that accurate or inaccurate that he didn't have any -- no prior mental health history?
A I'd say there's inaccuracy there.
Q And didn't he also -- wasn't he also prescribed Xanax and Klonopin prior to coming into the jail?
A That's what he said.
Q Isn't anxiety a mental health issue?
A Yes.
Q So this note that says he had never -- he had no mental health history, as you've testified or I think you've testified, that is inaccurate, correct?
A According to medical records, yes.
Q Thank you. One moment.
So according to this note, it indicates that David will be seen by a psychiatrist on Monday, correct?
A Correct.

Q So any explanation as to why this complicated case would require the psychiatrist to wait four days to go see him since this meeting on the 26th occurred on Thursday?
A The only thing I could do would be speculate. Obviously, the meeting -- I don't -- they probably don't put the whole notes in the -- in your healthcare service meeting here, what all was discussed. Obviously, medical thought he was stable. Mental health thought he was not responding to them but stable. And so they felt he could wait until Monday. Otherwise, Dr. Haque -- they could have said Dr. Haque, you need to see him today or send him out to the ER if they thought he was that unstable.
Q Does the -- is a person's nutrition important when somebody is in a high observation cell?
MS. SWINDLEHURST: Objection to form and foundation.
Q I'm going to ask it a little differently. Is somebody who was at the jail, is their -- is nutrition important?
A Yes.
MS. SWINDLEHURST: Same objection, form; foundation.

Q Go ahead, Doctor.
A Nutrition is important whether you're in jail or out of jail.
Q Tell me why it's so important.
A Just for proper body health.
Q Physical health?
A Yes.
Q And mental health?
A Can be, yes.
Q But at least physical health, correct?
A Correct.
Q Under whose direction or umbrella or auspices does an inmate's physical health fall --
MR. CHAPMAN: Objection to the form of the question.
Q -- in a jail setting?
MS. SWINDLEHURST: Same objection, form and foundation.
Q Doctor, go ahead and answer.
A Well, the -- a person's physical health is under the auspices of the medical department.
Q And how does the medical department make sure that somebody is getting adequate food or water?
A Well, it's up to the custody of the jail to actually see that inmates get their food,

nutrition, water, whatever. And generally medical, unless they're made aware of someone not eating or having issues with diet, inmates complaining about diet or custody, they would be unaware if there was an issue.
Q Would a medical director want to know what the procedure was for custody's monitoring of food and water intake?
MS. SWINDLEHURST: Object to form and foundation.
MR. CHAPMAN: Could you read the question back for me? I didn't quite get it. Could somebody please read the question back to me? I didn't hear it very well.
(Court Reporter begins to read the question back.)
Q I'll try to repeat it for you.
COURT REPORTER: Okay.
Q Would custody -- I'm sorry. Would the medical director want to know how custody was monitoring food and water intake of a patient or inmate?
MR. SWINDLEHURST: Form and foundation.
MR. CHAPMAN: Object to form and foundation. Speculation.
A They would want to be aware that they're being fed.

Q Well, what is the jail that you are medical director for? What's it called?
A Vanderburgh County.
Q And one other, correct?
A Vanderburgh County and Warrick County correctional facilities.
Q As the medical director there, do you know how custody monitors food and water intake of a patient in a high observation cell?
A Actually, no. I would hope they would let medical know -- the nurses or someone know if there's an issue going on.
Q Does custody monitor food and water intake in the jails that you oversee?
A Not on a close basis. If there's someone that is not eating on a regular basis or on a hunger strike or says they're not going to eat or drink, period, then they'll let medical know.
Q Well, what if somebody doesn't declare a hunger strike, but they just essentially don't eat or don't eat enough or drink enough to stay alive? Who would know that?
A Custody staff would let medical know if there's -- they feel there's an issue going on.
Q And how would they determine if an issue was going

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on?
MS. SWINDLEHURST: Objection, form, foundation, calls for speculation.
A I don't know exactly what their --
MR. CHAPMAN: Same objection.
A -- standards are, how much intake they -- before they'd notify medical.
Q So if somebody brings meals to an inmate in close observation and those meals don't get opened or eaten, but they get carried back out by the food deliverers and food pickup people, isn't that something that custody would be able to see?
MS. SWINDLEHURST: Objection to form and foundation.
MR. CHAPMAN: Objection, form and foundation.
MS. SWINDLEHURST: Calls for speculation.
MR. CHAPMAN: He's not here as a custodial expert, and he's not answering questions regarding custody.
Q Well, would you think, as somebody who was in charge of somebody's physical health, that -- strike that.
Are you -- as somebody who is in charge of somebody's physical health in the jail setting, are you just assuming that jail staff is evaluating

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somebody in high observation with respect to their food and water intake?
MS. SWINDLEHURST: Objection to form and foundation, calls for speculation.
MR. CHAPMAN: Objection to form and foundation. He's not a custodial expert. He's not here to testify on the requirements of being a custodial expert.
MR. IHRIE: No, but he's a medical director. And he just testified that somebody's nutrition is important. So I'm going to ask the question.
Q How do you determine -- as the medical director, whether or not somebody who has not declared a hunger strike but is simply not eating or drinking, how do you determine if that's occurring or not occurring, or how is that determined, rather?
MR. CHAPMAN: Objection, asked and answered. He told you how.
MS. SWINDLEHURST: Join.
Q So Doctor, you just assume that it's happening?
A (No response.)
Q Doctor?
A I don't know exactly how each facility manages that or oversees intake.
Q Well, in your jails --

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A I'd have to look at the custodian --
Q -- how do you -- I'm sorry.
A I'd have to look at the policies of our custody in regards to that.
Q All right. All right.
Dr. Sherman testified as follows, and I want to know if you agree or disagree with what he said, and I'm referring to page 139, line 23. I will read. "I tell you that unfortunately one of the issues in this case was failure to write notes and not just the nurses, but I was guilty of it. The director of nursing was guilty of it, and certainly the many nurses who saw him were guilty of that. It was a mistake of not sitting down and writing out things. I think a lot of times they feel that if they don't see anything significant that they don't really need to write it out. Obviously, that's not correct." Do you agree with that statement?
A Well, I agree that there was multiple times in the -- in this case that better note taking could have been done. I don't think the actual outcome or the treatments would have been any different with the notes. I think he was still managed appropriately from a medical standpoint.

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Q Is there any part of that statement that I read that you disagree with?
A (No response.)
Q Doctor?
A I agree with what Dr. Sherman said there.
Q Thank you. Do you have an opinion as to whether or not Nurse Monica Cueny saw David -- or I'm sorry, spoke with David Sherman on the 18th in person or on the telephone?
A That, I'm not sure. I would presume on the telephone, but I don't know.
Q Doctor, I'm going to ask you to look at page 130 of the Sherman dep.
A Okay.
Q I'm going to ask you to look at line 12, and I'll read it. "But the second thing is that not really expecting this to be a case that was going to come to litigation, I just wrote down the pertinent parts of that exam." Do you see those words?
A Yes.
Q Should whether or not what a doctor writes down in his notes be determined by whether or not he believes a case is going to come to litigation?
A Well, I -- I would suppose at times when you think there's a higher risk of litigation, you may

document a whole lot more, especially if an inmate says, I mean, even in my jail, said I'm going to sue the jail and everybody else, I would probably write a whole lot more than I would somebody that I would feel would be just a routine, everyday case.

MR. CHAPMAN: I would also object to the question. For completeness, you should have read everything the doctor said there on page 132 and 131. It's a much more fuller answer.

MR. IHRIE: You can cross examine him on that.

Q So is that a yes to my question then?

MR. CHAPMAN: You should do that.

Q Is that a yes to my question then, Doctor, that it's okay to write a different note depending upon whether or not you feel that the case may come to litigation or not?

A (No response.)

MR. CHAPMAN: Asked and answered.

Q Doctor, is that a yes?

A Yes, you may -- I mean, I've answered that already. You may document more on a higher-risk litigation case than a -- than a lower-risk.

Q Doctor, you've indicated that some of the symptoms that David was exhibiting could be considered signs of benzodiazepine withdrawal -- perhaps other

things but also benzodiazepine withdrawal, correct?

MR. CHAPMAN: Objection, mischaracterizes prior statement.

MR. IHRIE: All right.

Q Is what I said correct?

A You're going to have to repeat that again.

Q You had testified, had you not, that the symptoms that David was exhibiting could be signs of benzodiazepine withdrawal, but they also could be signs of other things such as a mental health problem, correct?

A Correct.

Q I'm going to draw your attention to page 59 of Sherman's dep. And I'm going to ask you to look at page 59, line 3 where it says the following: "Our feeling is that starting a patient on a withdrawal protocol is probably a safer step to protect them than to react to them if -- if they suddenly start showing signs of withdrawal. So we are proactive rather than responsive."

Would you agree that is a proper methodology of dealing with somebody who may be going into or may begin to show symptoms of benzodiazepine withdrawal?

A Yeah, that's typically what we do in my jail when a

patient enters the jail and says he's taking benzodiazepines or we confirm it with a pharmacy.

Q Is this case a typical case, or is this a complicated case?

A Well, obviously, with the outcome, it's a complicated case. We don't typically start a withdrawal protocol six or seven days after the person comes into the jail. We start it on the day they walk in. Usually by the sixth or seventh day, they've already gone through severe withdrawal if they're going to have severe withdrawal problems.

Q But in your report you indicate the symptoms can start six or seven days after cessation or abrupt stop, correct?

A Well, you can have -- going off long-term benzodiazepines, you can have some funny symptoms for, as you mentioned -- someone mentioned previously, for months and years.

Q And that's true, correct?

A Yes. They're generally not life-threatening events after being in for a week.

Q I would like you to look at your report, page five, please.

A (Witness complies with request.) Okay.

Q How long had -- on the 17th and 18th, how long had

David been in the jail? Your answer is going to be two separate numbers, I understand. But on the 17th and 18th, how long had David been in the jail --

A It's my understanding he came in --

Q -- starting on the 11th?

A -- on the 11th.

Q Right, he came in on the 11th. So on the 17th and 18th, how many days had he been in the jail?

A 17th seven, and 18th eight.

Q So if he got in on May 11th, 24 hours from the 11th, the first day would be on the 12th, correct?

A Well, the first day would be considered the day he came in the jail, on the 11th.

Q Well, I'm talking about a day being 24 hours. So 24 hours from the day he got in, the first day would have been completed on the 12th, correct?

A If you say 24 hours, I guess if you would --

Q The first 24-hour period?

A Sure.

Q Yes?

A Sure.

Q The second day would have been completed on the 13th, correct?

A Yes.

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Q And the third day on the 14th, the fifth day on the 15th, the sixth day on the 16th and the seventh day on the seven- -- I'm sorry, I think I'm one day off. So the seventh day would have been on the 18th, and the sixth full day would have been on the 17th, correct?
A Okay.
Q Now, I'm going to ask you to read the second sentence of your report on the first -- or second full paragraph. It starts "medically speaking." Please read it out loud.
A "Medically speaking, most of the significant benzodiazepine withdrawal symptoms will occur within the first few days or week of stopping this class of drugs, especially the short-acting ones like Xanax."
Q Thank you. So the 17th was a pretty eventful day for David, wasn't it?
A Well, he had stopped the medicine a week before he came in, so that was two weeks after he -- almost two weeks -- 13 days after he stopped taking the medication according to him.
Q When did he stop taking the Xanax?
A Well, one day -- as Monica says, one day he said Xanax, the next day he said lorazepam.

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Q So what day did he stop taking Xanax is my question?
A I don't know.
Q Does anybody know in the record? Do you see anywhere in the record where anybody knew the answer to that question?
A Well, I believe from Monica's note was that -- her thought was that he was not taking both; he was taking one or the other, but I don't know.
Q Well, you better look at her note for me, please, and tell me where it says that.
A At one point, she says one day he said he was taking Xanax, and the next day he's taking lorazepam, in her deposition.
Q Right. So in two days he acknowledged taking both -- two separate benzodiazepines, correct?
A Well, there was still, I guess, some confusion in my mind that he was taking them both at the same time, but he could have been, yes.
Q All right. So now tell me, please, in Monica's note where he indicated the last time he took Xanax.
A Don't know.
Q All right. So is there any record that shows the last time he had Xanax?

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A No, not that I know of.
Q Hold on. So if the last day he had Xanax was the day he came into the jail, that would have been six days after he was an inmate, correct?
A Yes.
MR. CHAPMAN: I object to the mathematics.
A Approximately.
Q How many days would that have been? Let me ask it differently.
If he took Xanax the day he went into the McComb County Jail, how many days was the 17th -- how many days would he have been in the jail on the 17th?
A Six.
MR. CHAPMAN: Object to form and foundation, mischaracterizes the evidence. We know when he took it. It wasn't then.
MR. IHRIE: How do we know, Ron?
Q If we know when he took it -- do you agree with that, Doctor, that quote/unquote we know when he took it, meaning Xanax?
A I don't know when he took it.
Q Thank you. Now, how many days -- if he took Xanax the day he went in on the 11th, how many days would it -- would he have been in jail on the 17th?

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A Six.
Q And isn't that within your -- the time period that you speak of and your report that says most of the significant withdrawal symptoms will occur within the first few days or weeks of stopping this class of drugs? Wasn't the 17th within the first few days or a week of when he came into the jail?
A It was the end of the first week. However, this case is interestingly pharmacokinetically quite complicated, in that if he was on lorazepam, which has a very long half-life of 30 hours plus, it will stay in your system for several weeks. So he would have been having lorazepam still in his system covering any withdrawal from Xanax during that first week, or even longer, to make it very complicated, if you want to get into that long discussion.
Q Would you please repeat that for me, Doctor? I want to make sure I understand what you're saying.
MR. CHAPMAN: Well, can we have -- wait, wait. Instead of repeating it, have the court reporter read it back.
MR. Ihrie: All right. Fair enough.
(The requested material was read back by the court reporter.)

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Q So Klonopin is lorazepam, correct?
A Correct.
Q And that is short acting or long acting?
A Long acting.
Q And Xanax is short acting, correct?
A Correct.
Q Would you expect a medical doctor that is medical director of a jail that has inmates that come into it that are either addicted or on prescription medication to know whether or not Xanax is a long acting or a short acting drug?
A I would expect them to probably know that, yes.
Q And would you expect them to know whether Klonopin is a long acting or a short acting drug?
A Yes.
Q What would you conclude -- did you read, rather, in Dr. Sherman's deposition that when I asked him which one was which, he didn't know?
A I'm not sure --
Q What would you conclude from that?
A I don't know if every physician would know that. But when you go to medical school and you go through training, you know which ones are the ones you've got to be more -- most careful with when you take them all. Xanax happens to be one of the ones

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for sure because it's short acting and you can have early withdrawal symptoms and the risk of death -- seizures and death. So those -- if you know someone that comes into your jail, you want to get them on withdrawal protocol right away.
This gentleman was interesting in the fact he had been on the long acting one and stopped it prior to the Xanax possi- -- I don't know when he -- honestly, I don't know when he stopped both of them. But if he did, he actually was self-tapering himself off Xanax, which is a very interesting case.
Q All right.
MR. CHAPMAN: I would also object to the prior question as mischaracterizing the record that that's what Dr. Sherman testified to.
Q So acknowledging the last comment, Doctor, Dr. Sherman, in testifying at least the day that I asked him, not knowing what was a long acting or a short acting, he wouldn't be able to make that kind of a conclusion, would he?
A Well, to discuss it further would be even if he did not have any clue about that. It's the short acting ones you worry about having the biggest risk of withdrawal, not the long acting ones. The long

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acting ones get out of your system very slowly whereas as short acting ones get out of your system quick. He knew the guy had been off of it at least for six days when he got the information about his whatever -- hallucinations, whatever. And so the risky period had already been over at that point of withdrawal. And that's why he felt he did not need to be put on the protocol or withdrawn further at that point.
Q So since he's taking two separate -- presuming he's taking two separate benzodiazepines, one short acting and one long acting, is it your testimony that the symptoms of withdrawal could show up either sooner or later because of the two half lives of the medication?
A Well, in my pharmacologic -- or I guess pharmacology background and doing clinical research trials for many years looking at half lives as well as working in jails and knowing the short acting versus long acting benzodiazepines, my comment would be the Xanax would get out of his system quick, but the other drug, Klonopin, will stay in it for longer and would still cover withdrawal from Xanax, most likely. And that's why he didn't have any symptoms in the first six days and why

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Dr. Sherman did not put him on another protocol or a taper.
Q When did he start to have symptoms of benzo withdrawal?
A Well, according to what you've told me, he started having those symptoms the day -- on the 17th.
Q Well, I'm not asking you to mimic what I said. You're the one -- you're the doctor and the expert, and you looked at the medical records. When did he begin to have symptoms of benzo withdrawal?
A I'm not sure he had symptoms of benzo withdrawal at all.
MR. CHAPMAN: I'm sorry. Could you repeat that, Doctor? I didn't hear you.
THE WITNESS: I said I'm not sure David had symptoms of withdrawal at all.
Q Is that your testimony, that he didn't have any withdrawal symptoms of benzodiazepine? Is that your testimony?
A My testimony is I'm not sure he had symptoms of benzodiazepine withdrawal at all. He may have had an underlying psychiatric condition that caused his symptomatology.
Q As the medical director of a jail, if you found out that your patient had been taking Klonopin and

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Xanax and was hallucinating and had been abruptly stopped sometime prior to entering the jail within a week or so and you saw those symptoms, what would you have done?
A A mental health consult.
Q With who?
A Well, our mental health department.
Q Well, a department isn't -- doesn't talk. People in the department do. So who would you have met with or consulted with?
A It could have been a social worker, could have been a counselor, could have been any one to go in and evaluate him.
Q And what would you have asked him to do?
A To evaluate the patient to see what they think's going on with him.
Q Assess the patient?
A Yes.
Q And what if they couldn't assess him? Would you expect them to report back to you?
A I would suspect -- I would refer them for mental health evaluation. I would hope they would refer them on for -- to evaluate them, do what they have to do and, I mean, similar to what happened in David's case; follow him and see what's going on,

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and at some point, if you're not getting anywhere, you get a psychiatrist involved.
Q And at what point weren't they getting anywhere?
A At what point?
Q In this case.
A Well, obviously, they had -- ended up having to have the care conference on the 26th. I presume they felt they weren't getting anywhere at that point and it's time to do something different.
Q So did Dr. Sherman refer him to mental health -- refer David to mental health?
A Well, I believe originally the -- the guards put him in the suicide watch because of bizarre behavior.
Q Now, answer my question. Did Dr. Sherman refer him to mental health?
MR. CHAPMAN: Objection. Don't be argumentative. He did answer your question.
MR. IHRIE: No, he didn't. I want an answer to that question.
Q Did Dr. Sherman refer him to mental health?
A I don't think Dr. Sherman did himself, no.
Q In fact, Dr. Sherman sent him back to the general population, correct?
A Correct.

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Q And that was on the 17th, correct?
A Yes.
Q And on the 18th, after talking to Cueny, he still didn't refer him to mental health, did he?
A Well, I believe at that point he was already placed in the mental health unit by the guards because of bizarre behavior the evening before.
MR. CHAPMAN: Mr. Ihrie, do you have any idea how much longer you're going to be?
MR. IHRIE: I don't think we're going to be that much longer, Ron.
MR. CHAPMAN: Okay. Thank you, sir.
Q Doctor, continuing, what was causing David's symptoms of hallucination, shaking, eye fluttering, et cetera? All the symptoms that he was identified with having by mental health, what was causing those?
A I wish I knew a hundred percent for sure.
Q Do you think that the mental health was curious about what was causing what they were seeing?
A Well, I think that's why --
MR. CHAPMAN: Objection, calls for speculation.
Q All right. Do you think they were curious?
A I think that's why eventually they got a mental

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health -- or a psychiatry consult set up.
Q At what point after your review of the records did they become curious as to why he was exhibiting those symptoms?
A Well, it seemed like those symptoms dissipated somewhat, but he just would not respond to mental health at all. But being as medical came by and checked him and he seemed to be stable, he was not changing much from the mental health standpoint, but he just never got better or different, they finally got him set up with a care conference and referred.
Q Now, what's the answer to my question? At what point did they become curious about what was causing his symptoms?
MR. CHAPMAN: Object to form and foundation, calls for speculation.
A I don't know.
Q I'm going to ask you to take a look at Chantalle Brock's notes dated June 18th.
A Which exhibit was that?
Q I'll tell you in a moment.
A On June 18th?
Q Yes. So one moment, please. All right. Do you have that, Doctor, the 18th note? I believe it was

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from Chantalle Brock.
A Yes.
Q Self-harm watch/mental health, do you have that?
A Yes.
Q All right. So if I understand, your testimony is that Dr. -- is that David was referred by medical to mental health -- or was referred at one point and was up in mental health and was going to be sort of handed off to mental health; is that correct?
A Well, the way I understood it was, he was having bizarre behavior, hallucinating, and the off- -- per observation from the officer put him in the mental health unit. And the next day on -- actually -- yeah, on the evening of the 17th. And then the 18th, that's when he was evaluated by Chantalle Brock. And she actually referred him to medical to be evaluated as well. And that's when Monica Cueny evaluated him.
Q So he was put into mental health, and then mental health -- the first time mental health went to see him, she said well, I've got to send this -- I want to -- I want to send him back to medical to have medical evaluate him because of refusing to engage with mental health staff, rapid eye movement,

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bizarre behavior, et cetera, correct? So she asked this to be reviewed by mental health -- or by medical again, correct?
A Correct.
MR. CHAPMAN: I'm going to object to form and foundation. It's a compound question and grossly mischaracterizes the evidence of why she made the referral.
Q Well, look at -- look at her note -- Brock's note self-harm watch on the 18th. Why did she make the referral, Doctor, back to medical?
MR. CHAPMAN: Object to form and foundation.
A Well, she based it on mental health consulted with the nursing staff to assess patient.
Q For what?
A For detox or a medical condition. Please refer to the nursing progress note which Monica Cueny did.
Q And so after that referral, that's what triggered Monica Cueny coming up to see him, correct?
A Correct.
Q And then Monica Cueny said after finding out that he was on Klonopin and that -- though we don't know if she reviewed -- if she saw Bertram's note, it was available to her, was it not?
A From what I understand, yes.

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MR. CHAPMAN: Object to form and foundation.
Q She then reported to Dr. Sherman her findings, correct?
A Correct.
Q And that was what she -- what she saw and allegedly reported to Dr. Sherman was a change in circumstances from what Dr. Sherman had seen with respect to David on the -- earlier on the 17th, correct?
A Well, she reevaluated him and actually had a more thorough note that day on the 18th.
Q And reported to Dr. Sherman -- allegedly reported to Dr. Sherman that there had been a change in what -- or a change later on the 17th and early on the 18th from what Dr. Sherman had seen when he evaluated him on the 17th, correct?
A There was some change, yes.
Q Dr. Sherman knowing that, please tell me why Dr. Sherman didn't reevaluate him.
A Well, according to the note it says case discussed with Dr. Sherman, no new order received at this time, but continue in -- to house in mental health high observation.
Q Is there anything in the medical record that you saw any orders of any kind with respect to David --

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David's medical treatment, from Dr. Sherman?
A Well, just with Monica Cueny's note about continuing to observe in the high -- mental health high observation unit.
Q Now, what's the answer to my question? Did you see in the medical record any notes or any orders of any kind relating to David Stojcevski from Dr. Sherman?
A I'd have to look through actually the record to see if there was any orders at all. Not that I recall, no.
Q All right. Thank you.
Continuing to look at Brock's self-harm watch on the 18th, do you see that Brock at the top of her note indicated that she was watching him on a self-harm watch, but she changed that to decompensation -- she marked decompensation reason for watch? Do you see that?
A Yes.
Q And what does that mean to you when you see that?
A Well, there's got to be a reason why are you putting someone on a 15-minute self-harm watch. What's the reason? You've got to have some kind of reason -- mental health has to have some kind of reason. So her reasoning is he's had a change in

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behavior or something needs to be followed more closely.
Q Now, you can't get much more closely than watching somebody 24 hours a day every 15 minutes on a video monitor, can you?
A Well, you can have --
MS. SWINDLEHURST: Object to form, foundation.
A You can have one-on-one observation where you're watching them 24/7 with one person watching them -- looking at them the whole time. That's done as well.
Q Did you see in every mental health self-harm watch document that the reason that he was placed in high observation was for -- because he was actively suicidal?
A Well, I saw -- I mean, he was placed in there by the officer because of bizarre behavior and possible hallucinations.
Q Doctor, have you had an opportunity to look at what it means for somebody to be placed in high observation green, which is where David was?
A What's the question?
MR. CHAPMAN: I'm sorry. What was the question?
Q Did you have an opportunity to look at what it

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means -- why one would be placed in high observation green in any of the records that you reviewed?
MS. SWINDLEHURST: Objection, form, foundation.
MR. CHAPMAN: Same objection. Join.
A Well, that there was concern of self-harm, that's why those boxes were checked.
Q Well, I want you to assume that high observation green is for people who are actively suicidal. After reviewing the records, did you see any indication at any time of David's stay where he was actively suicidal?
MS. SWINDLEHURST: Objection, form, foundation.
A Well, it's not uncommon in jails that the only reason you're put in a -- in the green smocked suit is because of being suicidal. There may be -- there may be a potential for suicide or there's concern the person's acting bizarre and could self-harm, so they may be put in green. But I did not see David, you know, doing self-harm to himself.
Q So your testimony is that you did not see any evidence in the records that David was actively

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suicidal; is that correct?
A No.
Q Is that -- I'm sorry. Is that correct?
A Or that's correct, yes.
Q Thank you.
Doctor, I'm going to draw your attention to page 59 of the Sherman dep. Please tell me when you're there.
A Okay. Just a minute.
Q And while you're getting there, Dr. Sherman believed, did he not, that somebody that had been on benzos -- strike that.
Dr. Sherman was aware, was he not, and believed that benzodiazepine withdrawal can last for a period of days, weeks or even months? He, himself, believed that, didn't he?
A If that's what he said.
Q He says that at line 17, correct?
A Yes.
Q So when he says, well, it had been awhile since he was -- since he stopped taking benzos, he believed that symptoms of withdrawal could last beyond a week or two, correct?
A A week.
MR. CHAPMAN: I object. Mischaracterizes

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testimony.
Q Well, that's what he says in line 17, doesn't he?
MR. CHAPMAN: Objection. In rule of fairness, you're not reading the entire portion and putting it in context.
MR. IHRIE: Well, you can cross examine him.
MR. CHAPMAN: Well, I'm just pointing out that you're misleading him.
A Well, my comment would be we discussed that probably several times earlier. But yes, benzodiazepine -- taking someone off that's been on them long-term, taking them off, they can have potentially withdrawal symptoms for months -- weeks, months or years. But the acute dangerous symptoms usually occur within days -- usually within the first week if it's -- especially for the short acting benzodiazepines. That's why when people come into jails, they put them on CIWA protocols or they put them on tapering doses when they know they're on it when they first come in.
Q So you've testified that the serious symptoms usually occur -- are within the first week, especially with the fast acting benzodiazepines? Like Xanax is fast acting, correct?
A Well, it's got --

MR. CHAPMAN: Objection, mischaracterizes his testimony.
MR. IHRIE: That's exactly what he said. That's exactly what he said.
MR. CHAPMAN: No, it is not.
MR. IHRIE: So if you want to read it back, we'll read it back. Please read it back. Please read it back, if you would, Ms. Court Reporter.
COURT REPORTER: I'm sorry. What are you asking me to read back?
MR. IHRIE: I'm going to ask you to read back about the last time that the doctor was speaking.
COURT REPORTER: Okay. Just a moment.
(The requested material was read back by the court reporter.)
MR. IHRIE: All right. Thanks. Okay. So back on the record.
Q So the acute serious symptoms that you're talking about from short acting usually occur within a week, you said, correct?
A Correct.
Q And Xanax is short acting, correct?
A Correct.
Q And David's symptoms occurred on the 17th within a week, correct?

MR. CHAPMAN: Objection, mischaracterizes the timeline and your mathematics.
MR. IHRIE: Well, from the 11th to the 17th is within a week, is it not?
MR. CHAPMAN: But you know that he wasn't incarcerated on the 11th. He was incarcerated on the 10th at Roseville and brought over on the 11th.
MR. IHRIE: All right.
Q So from the 10th to the 17th, that's approximately one week; am I correct?
A So generally significant --
Q Is that --
A -- withdrawal would happen within the first seven days, so that was actually after the first seven days.
Q So what are you going to do, Doctor? Are you going to nail this down to the exact hour and minute as to when the symptoms might begin, or can you say approximately within the first week?
A Well, I say in general. Every patient's --
Q In general. Thank you.
A -- obviously different. Some people are slow metabolizers, some people are rapid metabolizers. I could go all day talking about that, if that's what you want. But in general terms, if you look

at the literature, most people are going to have the significant problems within the first three to five days, usually. That's why you put people on protocols to taper them off. That's why when an alcoholic comes in, you put them on a long acting benzodiazepine such as Valium or librium for a few days. You don't do it long term; you do it for a few days because they self -- the drugs self taper. It's a long acting drug.
Q So a doctor who sees the patient and knows the patient has been taking a fast acting benzodiazepine and finds out about the symptoms that allegedly he was told by Monica Cueny -- if you were told of those symptoms, wouldn't you have put him on a benzodiazepine protocol just to be safe?
A Not after he's been there for a week.
Q Okay. All right.
Doctor, do you dispute the medical examiner's conclusions in this case in any way?
A Actually, to be honest with you, I was kind of surprised when I saw a -- I assume that it was a pathologist. But when they put in that report that it was a benzodiazepine withdrawal, I'm not sure how you could say that for sure from an autopsy,

but -- now, possibly, you know, because of the electrolyte imbalance -- and my guess was the person probably had an arrythmia and died from that or dehydration and electrolyte imbalance and arrhythmia. But to say it was from benzodiazepines for sure, I'm not sure I could say that. I'm not sure what you could do to prove that in an autopsy, what tissue would look like from benzodiazepine withdrawal.
Q Do you have expertise in making the determination as to why somebody, like in David's case, died?
A No, other than looking at he had, apparently, sodium electrolyte changes, and that actually can induce arrhythmias. And my guess, if I was going to speculate, that's probably what he died of, an arrhythmia.
Q Is it your testimony that the medical personnel did everything correctly in this case?
A Well, in my opinion --
Q And under medical -- excuse me. Under medical, I'm including what you have testified to, which includes medical including nursing and mental health.
A Well, I think, in general, medical did the appropriate thing. When he came in, they got a

history. They found out later that he had been on benzodiazepines. They -- he had already been tapered off it for a week. They had him on a COWS protocol when he first came in because he said he was taking Methadone. They ended up having him see mental health. They -- mental health seen him -- saw him every day. And medical kept seeing him and just kept doing vital signs that remained stable. He -- and then at a point he just didn't turn around, mental health got -- had a care team meeting; got a psychiatrist involved. Unfortunately, he expired. But I don't see where they grossly did gross negligence. They for sure didn't just leave him in a cell and let him rot away and never see the guy. They saw him every day. So I don't see any terrible mistakes that medical made to avoid taking care of him in a jail. They did what they -- they did what they thought was appropriate from the information they knew at the time.

Q And your testimony before was that he was monitored, but there was no treatment for him? Do you recall testifying to that?

A Well, he --

Q Do you recall that testimony?

A Yeah, he was monitored. They did not -- other than treatment from mental health evaluations, they didn't put him on specific medication for treatment, no.

MR. IHRIE: No other questions.

COURT REPORTER: Does anybody else have any questions?

MR. CHAPMAN: No, I have no questions.

MS. SWINDLEHURST: No, I don't have any questions either.

(Deposition concludes at 3:50 p.m.)

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

DAFINKA STOJCEVSKI, a/k/a STEPHANIE STOJCEVSKI, Individually, and as Personal Representative of the Estate of DAVID STOJCEVSKI, Deceased, Plaintiffs,

-v-

COUNTY OF MACOMB, SHERIFF ANTHONY M. WICKERSHAM, MICHELLE M. SANBORN, CORRECT CARE SOLUTIONS (CCS), LAWRENCE M. SHERMAN, M.D., DAVID ARFT, NATALIE PACITTO, MONICA CUENY, R.N., TIFFANY DELUCA, LPN, VICKI BERTRAM, LPN, SARA BREEN, LPN, MICAL BEY-SHELLEY, LPN, DIXIE DEBENE, LPN, THRESSA WILLIAMS, LPN, LINDA PARTON, LPN, AMBER BARBER, LPN, DEANN PAVEY, LPN, CHANTALLE BROCK, LPN, KELLY MANN, DANYELLE NELSON, MHP, OXLEY, COONEY, HARRISON, TALOS, PINGILLEY, AVERY, VANEENOO AND HELHOWSKI, Defendants.

Case No. 15-cv-11019

Job No. 128398

The deposition of RANDALL STOLTZ, M.D., taken in the above-captioned matter, on April 30, 2017, and at the time and place set out on the title page hereof.

It was requested that the deposition be transcribed by the reporter and that same be reduced to typewritten form.

STEWART RICHARDSON & ASSOCIATES
Registered Professional Reporters
20 N.W. Fourth Street
Evansville, IN 47708
(812) 477-4449

STATE OF INDIANA)
)
COUNTY OF WARRICK)

I, Sherry D. Lenn, RPR, and Notary Public in and for said county and state, do hereby certify that the deponent herein, RANDALL STOLTZ, M.D., was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the aforementioned matter;

That the foregoing deposition was taken on behalf of the Plaintiffs; that said deposition was taken at the time and place heretofore mentioned between 9:06 a.m. and 3:50 p.m.;

That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction; and that the typewritten transcript is a true record of the testimony given by said deponent;

I do further certify that I am a disinterested person in this cause of action; that I am not a relative of the attorneys for any of the parties.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 15th day of May, 2018.

_____
Sherry D. Lenn, RPR
Notary Public - State of Indiana
My Commission Expires: 08-02-2024

Job No. 128398